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ABSTRACT

This project investigated the learning support needs of post-secondary Australian students with a psychiatric disability for the purpose of maximizing student retention. Fifteen focus groups were held throughout Australia with students, prospective students, teachers, support staff, and management. In addition, three surveys were completed by 256 staff, 113 students, and 25 prospective students. The project identified the following themes: (1) extent of psychiatric disability in the higher education context; (2) concepts of mental wellness and psychiatric disability; (3) issues of disclosure and confidentiality; (4) university study as a stressful experience; (5) effects of disturbing behavior (staff and student perspectives); (6) resources; and (7) roles and responsibilities. Implications are drawn for best practice support (such as the importance of staff training), for best practice policy (such as the need for accommodations), and for staff training (such as knowledge of disability legislation and student rights). Individual sections of the report address research aims, definition and terminology, relevance of the research, previous research, legal implications for policy, methodology, emerging themes, results, and discussion. Appendices provide information on interview and focus group participants and the three survey forms. (Contains 63 references.) (DB)



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post-secondary institutions

Patricia McLean

Jana Andrews

August 1999

The line between mental health and illness is blurred; much is to be learned from one another across that line . . . Our understanding of the human condition is enhanced in the educational environments that value diversity of experience and expression and foster, through supportive policy and practice, the intellectual and personal growth of all who work and study within.

(Hoffmann & Mastrianni 1989)

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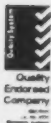
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The project team

The study was a University of Melbourne TAFE Collaboration (UMTC) project designed by Patricia McLean from the University of Melbourne and Margery Webster from Kangan Batman Institute of TAFE. Patricia McLean managed the project with co-researcher Jana Andrews from Kangan Batman Institute of TAFE. Tony Horan from Box Hill Institute of TAFE and Claire Pitman from the University of Melbourne were also involved in the initial process of data gathering. The project team was supported by a reference group with representation from peak bodies, TAFE staff, students and consumer groups.

Some additional funding from the DEETYA Co-operative Projects for Students with Disabilities enabled the project to be extended to university students. Focus groups in Sydney, Brisbane and regional Victoria were carried out with the assistance of Murray Bardwell (Australian Catholic University [ACU]) and Janette Ryan (formerly ACU, now University of Ballarat). The project team would also like to acknowledge the support of Murray Bardwell and Janette Ryan in obtaining and analysing data from regional Victorian, Sydney and Brisbane focus groups with teaching and general staff.

List of acronyms and abbreviations

ABI	acquired brain injury
ABS	Australian Bureau of Statistics
ACU	Australian Catholic University
ADD	attention deficit disorder
ADHD	attention deficit hyperactivity disorder
AIDS	acquired immune deficiency syndrome
Anorex.	Anorexia Nervosa
ANTA	Australian National Training Authority
Asp.	Aspergers Syndrome (an autism spectrum disorder)
BPD	bipolar disorder
DDA	Disability Discrimination Act
DEETYA	the former Department of Employment, Education, Training and Youth Affairs: now DETYA, Department of Employment, Training and Youth Affairs
DID	disassociative identity disorder
DLO	disability liaison officer
DSM IV	American Psychiatric Association's Diagnostic and Statistics Manual
FEO	equal employment officer
EPPIC	Early Psychosis Prevention and Intervention Centre
HE	higher education
LD	learning disability
MASC	Mental Awareness of Students on Campus
OCD	obsessive compulsive disorder
PD	personality disorder
PTS	post-traumatic stress disorder
SANE	A national not-for-profit organisation which campaigns for understanding of mental illness. Founded in 1986 as Schizophrenia Australia, it adopted SANE Australia as a new business name in 1996. (SANE has a sister-organisation in the UK, which originally took the title of SANE in 1986. The two organisations are quite distinct, but communicate regularly and work in close association.)
SEL	socio-economic level
SEP	supported education programs
SPSS	A software package originally entitled Statistical Package for the Social Sciences. As usage has changed, the company now considers SPSS to stand for Statistical Product and Service Solutions.
TAFE	technical and further education
UMTC	University of Melbourne TAFE Collaboration
VCE	Victorian Certificate of Education
VET	vocational education and training
WHO	World Health Organisation

Executive summary

Project aims

The aim of this study was to investigate the learning support needs of post-secondary students with a psychiatric disability with a view to maximising student retention rates.

Hoffmann and Mastrianni (1989, p.915), commenting on American post-secondary institutions, note:

no college is immune from the question of how to approach, in policy and practice, the mentally ill, suicidal or chemically addicted student.

The same can be said of Australian campuses; three-quarters of those who contract mental illness, do so between 16 and 25, an age when most young people are likely to embark on post-secondary education and training programs.

Psychiatric illness has a profound effect on the learning capacity of a significant number of Australian students and one in five adults will suffer a mental illness at some time in their lives (National Mental Health Policy 1992; Mental Health Strategy Plan 1994).

Anti-discrimination and equal opportunity legislation at State and federal levels have made it unlawful to discriminate against people with disabilities and medical conditions including those with disability related to mental health functioning. In response to this legislation, federal policies have set national objectives and targets and strategies for ensuring that benefits for post-secondary education are available for all. These strategies make the following assumptions:

- 1 Post-secondary students with psychiatric disabilities have identifiable additional learning needs.
- 2 The provision of support for students with psychiatric disabilities will have positive implications for the participation and success rates of these students.
- 3 The post-secondary education system response to the learning needs of students with psychiatric disabilities can be enhanced through the provision of appropriate support.

This project aimed to demonstrate these assumptions and provide insight into best practice support programs, by reviewing the perceptions of key stakeholders (students and prospective students, teaching staff, support staff and management) of the additional learning support needs of students who have a psychiatric disability.

Methodology

Focus groups were set up with students, prospective students, teachers, support staff and management. A total of 15 focus groups were held; while the majority were in Victoria, one was held in Queensland, one in New South Wales and one

in South Australia. In addition to the focus groups, discussions were held with staff from mental health and educational organisations and consumer groups. Additional funding from a Department of Employment, Education, Training and Youth Affairs (DEETYA) Co-operative Projects for Students with Disabilities grant enabled the project to be extended to the higher education as well as vocational education sector.

While focus group data were analysed qualitatively and used to establish themes and responses, the transcribed responses were also used to inform the development of a series of three surveys (student, prospective student and staff) which were sent to consumer groups in Victoria and to every TAFE and higher educational institution in Australia. The survey responses were analysed utilising SPSS. There were 256 respondents to the staff survey, 113 respondents to the student survey and 25 respondents to the prospective student survey.

Issues

The qualitative aspect of this research project has raised a number of issues as being significant. Perhaps not surprisingly, the conclusions drawn by different stakeholders vary markedly. The following themes were evident:

- ♦ extent of psychiatric disability in the higher education context
- ♦ concepts of mental wellness and psychiatric disability
- ♦ issues of disclosure and confidentiality
- ♦ university study as a stressful experience (compounded for students who are living away from home)
- ♦ effects of disturbing behaviour (staff and student perspectives)
- ♦ resourcing (including legal and policy implications)
- ♦ roles and responsibilities
- ♦ implications for training

Implications for best practice support

The research has clear implications for best practice in the provision of support for students with psychiatric disabilities.

The research affirms that best practice is indicated when:

- ♦ staff training includes issues such as: concepts of mental wellness and mental disorder, knowledge of options for assessment, information about medication and side effects, empathic skills, knowledge of 'boundaries' (avoiding taking unnecessary responsibility for a student)
- ♦ there is clarification of confidentiality responsibilities
- ♦ the amount of time taken by this group of students is acknowledged in staff resources (that this group took a very high percentage of staff time was a factor for almost all staff participants)
- ♦ there is encouragement of a culture of diversity not difference
- ♦ peer support programs are facilitated
- ♦ support alternatives which don't involve disclosure are available (e.g. quiet space where student can retreat, specialist study skills support, peer support)

- ♦ bridging schemes are available which develop personal, professional and study skills (supported education programs in the United States offer a range of best practice models)
- ♦ safety procedures are in place for both students and staff
- ♦ independent mediation is available
- ♦ there is sufficient flexibility in course delivery, course completion times and course structure

Implications for best practice policy

Understanding and addressing the learning needs of students with psychiatric disability have a number of implications for policy both at the level of the individual institution and nationally. Regulations regarding course completion times and assessment methods need to be reviewed in light of the needs of the target group. Additionally, industry plays a major role in shaping training yet, in general, there is little awareness by employer groups of either the training needs or the range of employment services and opportunities for people with disabilities. In the case of those with psychiatric disabilities, these issues are compounded by the stigma of mental illness. Effective fieldwork co-ordination with appropriate support may be critical to a successful work placement which is an essential requirement in many courses. In the light of disability discrimination legislation, it is desirable that there is intra-institutional and inter-institutional consistency in accommodating the needs of students with psychiatric disability.

Federal and State disability legislation and the policies indicate the following:

- ♦ Accommodations should be provided unless unjustifiable hardship can be substantiated.
- ♦ There should be a consideration of the benefits as well as the costs of accommodations (for example, creativity in education, tolerance, affirmative action and accommodation of others in the future as well as the present).
- ♦ Course selection should not presume an employer's judgement of meeting the inherent requirements of the job.
- ♦ Selection cannot prescribe a level of wellness as a prerequisite, unless unjustifiable hardship can be clearly demonstrated.
- ♦ Time extensions such as double-time can be negotiated up-front.
- ♦ The disorder/illness must have ongoing impact in order to obtain accommodations.
- ♦ Institutions need to ensure that fieldwork placement should not place students where there is foreseeable risk of harm to self or others.
- ♦ In situations of threat to safety or fear, the student need not be accommodated. However, it is advisable to avoid liability and therefore do as much as possible to accommodate the student.
- ♦ Normal duty of care provisions apply in educational institutions (for example, support staff are expected to possess and utilise special skills and knowledge). Confidentiality can be broken when there is a perceived threat to self or others.

The Disability Discrimination Act (1992) confers accommodations to students with disabilities unless it would constitute 'unjustifiable hardship'.

Accommodations which allow the student to meet requirements and enjoy benefits must be provided in the most dignified, appropriate and least onerous manner possible.

All stakeholders (students, support staff, teaching staff and administrators) acknowledged the need to enhance the support available in this area. Of the counsellors and disability liaison officers surveyed, 72 per cent (n=129) noted an increase in the number of students who disclose or manifest signs of mental disorders, with 40 per cent of these reporting clear statistical evidence of the rise.

Implications for staff training

It was clear from this study that the issue of psychiatric disability among students was both serious and pressing for academic and support staff.

Survey responses and focus group discussion suggest that training for staff who work with students with psychiatric disability should include:

- ♦ guidance in identifying behaviours which might 'trigger alarm bells'
- ♦ information about the possible side effects of medication
- ♦ knowledge of disability legislation and student rights
- ♦ mental health awareness issues
- ♦ knowledge of alternative assessment options
- ♦ training in empathy skills
- ♦ implications for field work and employment
- ♦ information on learning issues and support
- ♦ guidance in determining the boundaries of appropriate relations and responsibility
- ♦ guidance in handling particular situations or behaviour
- ♦ confidentiality guidelines
- ♦ non-discriminatory selection guidelines
- ♦ advocacy and negotiation options

Outcomes

In addition to the following report, the project team has developed a resource kit for disability support staff and a resource kit for students, based on report findings. The resource kits are intended to address some of the issues raised by the report's findings.

Research aims

The aim of this project is to investigate the learning support needs of students who have a psychiatric disability and are studying, or intend studying, in Australian post-secondary institutions. Post-secondary institutions including both Technical and Further Education (TAFE) and private providers in the vocational education and training (VET) sector as well as higher educational institutions Australia-wide were included in the study.

Anti-discrimination and equal opportunity legislation at State and federal levels have made it unlawful to discriminate against people with disabilities and medical conditions including those with mental health problems. In response to this legislation, federal policies such as *A fair chance for all: Higher education within everyone's reach* (1990) have set national objectives and targets and strategies for ensuring that benefits for higher education are available for all. These strategies assume the following propositions to be true.

- 1 Post-secondary students with psychiatric disabilities have identifiable additional learning needs.
- 2 The provision of support for students with psychiatric disabilities will have positive implications for the participation and success rates of these students.
- 3 The post-secondary education system response to the learning needs of students with psychiatric disabilities can be enhanced through the provision of appropriate support.

This project aimed to demonstrate these propositions by reviewing the perceptions of key stakeholders (students and prospective students, teaching staff, support staff and management) of the additional learning support needs of students who have a psychiatric disability, in the light of current disability policy.

To demonstrate these propositions and determine the learning support needs of students with psychiatric disability requires the following questions to be answered.

Research questions

- 1 What definition of *psychiatric disability* best applies in the context of the post-secondary education sector?
- 2 What are the specific learning needs of this target group in the tertiary education context as perceived by (a) consumers, (b) service providers and (c) institutional administrations?
- 3 What is the current experience of this target group? That is:
 - a) How is their participation limited?
 - b) How is their participation supported?
 - c) What policies currently inform practice?

- 4 Does the target group perceive a satisfactory level of acceptance by the post-secondary education community (students, staff and administrations)?
- 5 What are the delivery modes/media and assessment methods which best accommodate the needs of the target group?
- 6 What additional supports are required to increase participation rates and facilitate successful educational outcomes for students with psychiatric disabilities?
- 7 What are the most effective strategies to implement these supports?
- 8 What are the implications of the findings for policy in post-secondary educational institutions?

Definition and terminology

Variation in terminology and definition impacts both on estimated incidence of psychiatric disability and on provision and evaluation of support services. A review of the literature and of program evaluations indicated that while the literature relied on medical models of definition, human services evaluations (both in educational and mental health spheres) relied on disability legislation for clarification of definition. There was similar variation in terminology used; consumer groups appeared to prefer non-problematizing terms such as *mental health issues* while educational organisations tying support programs to anti-discrimination legislation continued to use *psychiatric* or *psychological* disability. More common in mental health organisations were the terms *mental health problems* and *mental disorders*.

Definition

In the literature, there is significant diversity relating to definitions of psychiatric disability. Many of the definitions are based on a medical model and rely on a symptom-based approach. As Wortley (1992) suggests, while the medical model is recognised as a method of diagnosis and labelling of disease, it may not be as useful in the context of post-secondary service provision because it fails to consider adequately the transient or long-term disabling effects from an acute phase of mental illness. Significantly for post-secondary educational institutions, clarification of definition is now also available in the international and national legislation which exists as a basis for rights and service provision for people with disabilities.

In the *Mental Health Act, NSW (1990)*, psychiatric disability is referred to as:

A condition which seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence of one or more of the following symptoms:

- a) delusions*
- b) hallucinations*
- c) serious disorder of mood*
- d) sustained or repeated irrational behaviour.*

The Disabilities Services Bill (1992) indicates that manifestation of these symptoms can be either chronic or episodic in nature and that they may result in significantly reduced capacity to engage in at least one or more of major life activities such as communication, learning, mobility, decision-making and self-care.

In the *Disability Discrimination Act (DDA) 1992*, disability relevant to the psychiatric or mental disorder domain is defined as 'a disorder, illness or disease that affects a person's thought processes, perceptions of reality, emotions or

judgement or that results in disturbed behaviour'. Mental health problems or mental disorders could also include a total or partial loss of mental functions. Disorders classified in the DSM IV are recognised for the purposes of the DDA as are other recognised classification systems.

Mental disorder is medically defined as a:

... clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress, or disability (i.e. impairment in one or more areas of functioning), or with significantly increased risks of suffering death, pain, disability or loss of freedom.
(DSM IV, p.xxi)

This definition includes references to disability. However, it is the DDA definition of disability that is more relevant for the purposes of anti-discrimination measures.

Terminology

The terms *psychiatric* and *mental disorders* belong to the medical speciality of psychiatry. The term *psychiatric* has been in usage because of medical convention. The term *mental illness* also has a strong medical flavour, as do restrictive definitions such as 'a medical condition that is characterised by a significant disturbance in thought, mood, perception or memory' (Victorian Mental Health Act). Operationally, the more appropriate term may be *mental disorder* for the condition (as in the DSM IV) and *mental disability* for the disorder's detrimental effects on functioning in life tasks such as learning. However, because *mental disability* could be confused with intellectual disability, preferred alternatives are *mental health disability* or *impairment*.

Discussions with consumer groups indicate that the terminology 'psychiatric disability' is unpalatable to many students. *Psychiatric* is not used by the World Health Organisation (WHO prefers *mental*) and *mental illness/disorder* is not usually linked with disability by many students. Moreover, it is important to acknowledge that a mental disorder does not always lead to disability or impairment.

The issue of definition is compounded further because diagnoses do not always offer a clear identification, in that:

- ❖ some students don't have a formal diagnosis
- ❖ some prefer not to be diagnosed
- ❖ some don't want to acknowledge their mental disorder
- ❖ some disagree with their diagnosis
- ❖ some diagnoses are tentative or fluid
- ❖ some students interpret the diagnosis in very culturally contextualised ways

Further, students are very aware of the potential stigma a diagnosis carries. As a TAFE student with a psychiatric disability claimed:

... diagnosis can be a double-edged sword, on one hand it can legitimise the pain, but labels can be abused and negative attitudes can be attached like unwanted baggage.

The term psychiatric disability is still the term used most often by support staff and administrators in post-secondary institutions, but it is increasingly being replaced by *mental health impairment*. Confusion/dissatisfaction over terminology remains a potential impediment to service provision.

Time frames and onset of mental disorders

The heterogeneity of mental disorders is also a factor in definition, and time frame and onset are part of this complex picture. The longevity of mental disorders varies greatly. Some are by definition of shorter duration, such as an acute stress disorder. Some can be long term, such as autism or personality disorders. With some disorders, such as schizophrenia, outcomes vary in that a third of those diagnosed recover within months, a third recover somewhat, and a third have significant continuing symptoms. Some people with mental disorders seem to recover spontaneously, many recover through treatment and support, and some do not recover for a long time even with treatment.

The onset of many mental disorders occurs in adolescence or early adulthood, and many students in post-secondary education may be experiencing signs and symptoms of mental health impairments for the first time. Identification of a mental disorder and acceptance of the need for treatment may take a long time, and efforts are directed by some mental health services (e.g. EPPIC in Victoria) to provide early intervention and even prevention (through identifying pro-dromal or indicative signs and symptoms).

Relevance of the research

Hoffmann and Mastrianni (1989, p.915), commenting on American post-secondary institutions, note:

no college is immune from the question of how to approach, in policy and practice, the mentally ill, suicidal or chemically addicted student.

The same can be said of Australian campuses; three-quarters of those who contract mental illness, do so between 16 and 25, an age when most young people are likely to embark on post-secondary education and training programs. Psychiatric illness has a profound effect on the learning capacity of a significant number of Australian students and one in five adults will suffer a mental illness at some time in their lives (National Mental Health Policy 1992; Mental Health Strategy Plan 1994). The most common illnesses are schizophrenia and psycho-affective disorders (bipolar affective disorder, anxiety and depression); these are a serious but treatable group of illnesses which can affect the brain and interfere with a person's ability to think, feel and act.

Incidence of mental health problems

There are various ways of estimating numbers of people with mental health problems who may be interested in using post-secondary education facilities. Lawn and Jones' (1997) review estimated demand for support in their West Australian report on post-secondary education and training options for people with mental health problems. They suggest that using broad epidemiological estimates and assuming these are representative of the post-secondary population gives a relatively high estimate and is subject to a high level of variability stemming from considerable variation in methodology and definitions.

For example, the Australian Bureau of Statistics (ABS) National Health Survey 1989-90 suggests a figure of <0.9 per cent of people aged 15-24 experiencing mental health problems as long-term conditions. Prevalence of schizophrenia (median age onset of 19 years; average deviation 5.9 years) is quoted at a one-year prevalence of 1 per cent for Western countries. Another chronic condition, depression, is quoted with a one-year prevalence of 3.7 per cent. Bipolar affective disorder (median age onset of 19; average deviation of 5.9 years) is thought to have a one-year prevalence of 0.6 per cent-0.8 per cent. Anxiety disorders are more prevalent; Rey (1992) suggests 4 per cent in women and 3 per cent in men, combining these with somatisation, post-traumatic stress disorder (and assuming all cases are separate).

Lawn and Jones (1997) suggest these prevalence rates show a total prevalence rate of 10 per cent for serious mental disorders. Even higher prevalence rates are suggested by Zubrick (1995) in the West Australian Child Health Survey. For example, 20 per cent of the 12-16 year group were identified as having at least

one mental health problem or disorder. The National Mental Health Strategy Report (1992) estimates that each year 4 per cent of Australians experience serious mental illness. About 30 per cent of people attending general practitioners (GPs) suffer identifiable psychiatric disorders, most commonly, depression and anxiety.

Table 1: One-year prevalence of mental disorders by age in 1997

18-24	26.6%
25-34	21%
35-44	19.9%
45-54	17.5%
55-64	12.3%
65+	6.1%
Total	17.7%

Source: ABS 1997, *Mental health and well-being profile of adults in Australia*.

It is estimated that 20 per cent of all Australians will experience a mental disorder in any one year (SANE 1998). The estimated prevalence of 'severe' mental disorders over a year is 3 per cent (which includes schizophrenia, bipolar disorder, severe depression, panic disorder and obsessive-compulsive disorder). The estimated prevalence for other disorders in Australia is as follows:

Table 2: One-year prevalence of mental disorders in 18-24 year olds

	Male	Female	
Anxiety	11.2%	8.6%	13.8%
Affective	6.7%	2.9%	10.7%
Substance abuse	16.1%	21.5%	10.6%
Total	26.6%	27.3%	25.9%

There are trends emerging world wide that indicate an increase in some mental disorders, especially in depression. These students will be entering post-secondary education, often untreated, and may struggle to cope with the academic and interpersonal demands of study.

Prevalence of mental health problems in post-secondary education

Kessler, Foster, Saunders and Stang (1995) investigated the impact of psychiatric disorders in the United States, concluding that 14.2 per cent of high-school drop outs and 4.7 per cent of college drop outs were persons with mental disorders. A mental health needs survey was conducted at Columbia University in the United States (Hoffmann & Mastrianni 1989). This sampled a representative group of all

students at the university, finding that the majority (50%–75%) of non-users of student mental health services have some impairment with less than 10 per cent meeting criteria for serious psychiatric disorders. Approximately 25 per cent of

Table 3: One-year prevalence of mental disorders in 1997

Anxiety	
Post-traumatic stress disorder	3.3%
Generalised anxiety disorder	3.1%
Social phobia	2.7%
Panic disorder	1.3%
Agoraphobia	1.1%
Obsessive-compulsive disorder	0.4%
Total	9.7%
Affective	
Depression	5.1%
Dysthymia (depressive personality)	1.1%
Total (includes bipolar and mania)	5.8%
Substance use	
Alcohol harmful use	3.0%
Alcohol dependence	3.5%
Drug use disorders	2.2%
Total	7.7%

Columbia's population said that suicidal/homicidal thoughts were a concern, and 19 per cent mentioned concern with sexual assault/harassment. Depression was a concern for 75 per cent of all respondents (with 19% stating it was a crucial concern). Academic concern variables indicated in the survey were: improving concentration, study skills, assignment completion, handling competition, time management, ability to clarify and meet goals, and overcoming fears about taking exams. This survey also raised interesting issues about cultural differences in dealing with psychiatric disabilities; Asian students in the survey had significantly more concerns about academic issues and on a variety of mental health issues. Asian students were also less likely to have had previous encounters with mental health practitioners, and Hoffmann and Mastrianni (1989) conclude this group is less likely to receive mental health support on their return home.

Interest in this issue in Australia is more recent, but extrapolating prevalence from the general population to post-secondary students is not straightforward. It has been argued that people with mental disorders are less inclined to study because of their impairments or hospitalisation, and rehabilitation has focussed

on employment and, recently, psychosocial outcomes rather than education and training. Anecdotal evidence from discussions with staff in the mental health sector indicate that with the deinstitutionalisation of the mentally ill and more effective medical and psychological treatments, there are many people in the community in a state of partial or complete recovery willing to take on study commitments.

The majority of counsellors and disability liaison officers surveyed (72%: n=129) noted an increase in the number of students who disclose or manifest signs of mental disorders (with 40 per cent of these reporting clear statistical evidence of the rise).

Impact of State and Commonwealth legislation and policies

The relevance of this research lies not only with the high level of incidence, but with the need for compliance with State and federal legislation. The development of mental health policies over recent years has considerably strengthened the rights of people with mental health problems. These policies, in conjunction with the Burdekin Report (1993) have provided an impetus to the reform of mental health legislation and service delivery.

The Mental Health Statement of Rights and Responsibilities (1991) was developed by the National Mental Health Consumers Outcome Task Force and was adopted by Australian Health Ministers in 1991. The statement aims to ensure consumers, carers, advocates and service providers are aware of their rights and responsibilities. Lawn and Jones list the rights of consumers which specifically relate to education and training:

- ❖ *the equal right to health care, income support education, employment, housing, transport, legal services, equitable health and other insurance and leisure appropriate to one's age*
- ❖ *the right to contribute and participate as far as possible in the development of mental health policy, provision of mental health care and representation in mental health consumer interests*
- ❖ *the right to live, work and participate in the community to the full extent of their capabilities without discrimination*
- ❖ *the right to expect that factors contributing to the development or exacerbation of mental health problems and mental disorders will be identified, and where possible, strategies will be implemented to minimise the impact of these factors and*
- ❖ *the right to expect that educators and other non-health professionals will receive sufficient education to enable them to recognise and refer people who may have a mental health problem or mental disorder to appropriate sources of assistance*

(Lawn & Jones 1997, p.13)

The National Mental Health Policy (1992) is a joint statement made by the Health Ministers of the Commonwealth, States and Territories of Australia which is intended to establish direction for the future development of mental health services and which reinforces the aims of the mental health policy. The policy specifically links mental health services with other sectors:

Specialised mental health services can only meet some of the varied needs of people with severe mental health problems and mental disorders. Access to housing and employment and training opportunities may have a significant

impact on the capacity of a person with a severe mental health problem or mental disorder to manage in the community.

(Australian Health Ministers 1991, p.19)

Anti-discrimination and equal opportunity legislation at State and federal levels have made it unlawful to discriminate against people with disabilities and medical conditions including those with mental health problems. The *Disability Discrimination Act* (1992) has three key aims which are to:

- 1 *eliminate discrimination against people on the grounds of disability in specified areas*
- 2 *ensure that people with disabilities have a right to equal treatment before the law, and*
- 3 *promote community understanding that people with disabilities have the same fundamental rights as the rest of the community*

The DDA defines disability to include:

... any disorder, illness or disease that affects a person's judgements or that results in disturbed behaviours and includes a disability that presently exists or previously existed but no longer exists or may exist in the future or is imputed to a person.

(Commonwealth Attorney General's Department 1994, p.19)

The DDA strengthens the *reasonable accommodation* provisions of most State or Territory legislation by requiring potential discriminators to make necessary adjustments and accommodations for a person with a disability unless there is unjustifiable hardship. Under the DDA a person with a disability is able to complain about unfair treatment. The DDA prohibits discrimination associated with enrolment in, or admission to, any school, college, university or other training or educational institution. The educational authority is responsible for discriminatory acts of its employees. Institutions are also required to provide an environment conducive to learning as well as support services such as counselling.

Under the DDA it is unlawful for educational authorities to refuse to admit a person with a disability on the grounds that the person is unlikely to be able to work in the profession or trade because of his or her disability. Qualifying and vocational bodies may refuse to authorise or qualify a person if, because of the disability, they are unable to carry out the *inherent requirements* of the trade or profession but educational authorities are not able to pre-empt the decisions of the qualifying body (Commonwealth Attorney General's Department 1994).

Discrimination in education is unlawful except:

- ♦ where the educational institution is only for people with a particular disability and the person does not have that disability
- ♦ if the person requires adjustments which may impose unjustifiable hardships on the educational institution

Decisions on cases of unjustifiable hardship are made on a case-by-case basis, bearing in mind the purposes of the Act. The DDA encourages the provision of special measures for people with a disability to ensure they have access to equal opportunity including positive discrimination.

The Commonwealth Disability Service Act acknowledges the right of people with disabilities to appropriate services which are tailored to their individual needs and aspirations.

At the moment, while there are a number of initiatives for education and training in the general population, policy specifically related to students with mental health problems is limited. The major policy documents are listed below.

FlexAbility: A strategic framework for people with disabilities in TAFE 1994-1996 provides a framework to assist State and Territory TAFE systems. It aims to improve the capacity of educational institutions to respond to the needs of people with disabilities, including those with mental health problems.

A fair chance for all: Higher education within everyone's reach (1990) sets national objectives and targets and strategies for ensuring that benefits for higher education are available for all. Strategies to achieve the objectives of increased participation rates include:

- ❖ special equipment and facilities
- ❖ advisors
- ❖ distance education opportunities
- ❖ modified materials and curriculum
- ❖ flexible timetabling and course requirements
- ❖ information about services available for students with disabilities

Implications of the Disability Discrimination Act for TAFE systems in Australia (1995) recommends proactive measures such as developing standards and action plans, interprets some key DDA terms and issues, and recommends comprehensive staff training and student awareness raising.

Tracking activity under the DDA and providing effective mechanisms for addressing and conciliating complaints is also suggested.

Operational guidelines for staff employed to provide services and programs to students with disabilities in TAFE colleges (1993) is a comprehensive document addressing a range of operational and legal issues for disability liaison staff.

The *Equality, diversity and excellence: Advancing the National Higher Education Equity Framework* (1996) report assesses the progress of the initial equity objectives set out in the White Paper of 1988 and further enunciated in *A fair chance for all*. The report reviews the range of management and organisational structures in place and concludes that good equity practice exists when:

- ❖ equity forms part of the corporate policies, or mission, adopted by the university's governing body
- ❖ equity has senior advocacy in the institution
- ❖ there are sufficient numbers of dedicated staff suitably placed, or with the skills necessary to influence senior management effectively
- ❖ there is an understanding of the present and potential student population of the university
- ❖ the university has a student-centred approach to teaching and learning that emphasises the identification of, and response to, the needs of students
- ❖ there is an effective organisational structure in place for equity in which responsibilities are clearly identified, and which is linked in the mainstream planning and decision making processes within the institution, and
- ❖ there is regular monitoring and evaluation of the institutions' progress towards the goals set in the plan

Planning together: The key to better outcomes (DEETYA 1996) noted that the Australian National Training Authority (ANTA) had identified a range of issues requiring attention if the VET sector was to be attuned to the needs of people with a disability (including those with psychiatric disability). This includes greater co-ordination between education, industry, welfare and employment service agencies in policy development, planning and delivery of VET for people with a disability.

Equity 2001 strategies to achieve access and equity in VET for the new millenium (ANTA 1996) noted the need to ensure that policy, planning, funding and delivery mechanisms for VET are inclusive of the needs of all Australians.

Developing standards under the Disability Discrimination Act for student services in vocational education and training (1997) is a guide to methodology for grass roots development of meaningful standards, using a range of key stakeholders and identifying priorities and options for appropriate standards.

Bearing of research on policy

Henry (1996) comments that 'in essence, VET has been a top-down, nationally driven policy agenda, with wide discrepancies between the view from the top ... and practices on the ground' (p.5). Henry also suggests that in the market context, 'the notion of equity is being reframed from a group oriented conceptualisation of disadvantage' (p.8) into a more individualistic notion of client choice. The challenge indicated in ANTA's Access and Equity Planning Model (ANTA 1995) is to build a closer customer (consumer) orientation and begin to detail the changes in the profile of delivery necessary to achieve the desired outcomes. Understanding and addressing the learning needs of students with psychiatric disability has a number of implications for policy both at the level of the individual institution and nationally. Regulations regarding course completion times and assessment methods need to be reviewed in light of the needs of the target group. Additionally, industry plays a major role in shaping training yet, in general, there is little awareness by employer groups of either the training needs or the range of employment services and opportunities for people with disabilities (Barker 1995). In the case of those with psychiatric disabilities, these issues are compounded by the stigma of mental illness. Effective fieldwork co-ordination with appropriate support may be critical to a successful work experience placement which is an essential requirement in some courses. In the light of the disability discrimination legislation, it is desirable that there is intra- and inter-institutional consistency in accommodating the needs of this target group.

Both Australian and North American campuses have seen increasing diversity in their student populations (McMullen 1992; Hoffmann & Mastrianni 1989). This has arisen because of social change in an increasingly multicultural society, economic necessity (with increasing numbers of international students) and through affirmative action or discrimination legislation. Since the passing of the Disability Discrimination Act (1992), discrimination against individuals with a psychiatric disability has been illegal in Australian educational institutions. While issues related to mental illness affect only a small proportion of students, institutional fallout from litigation and negative publicity is disproportionately large.

In addition to problems associated with learning experienced by all post-secondary students, VET students with psychiatric disability experience a unique set of problems. There are often gaps in their curricula vitae or their academic record, and lack of understanding of the nature of psychiatric disability means that employers and teachers often try to steer students to less challenging courses or career paths. Because of the diversity and nature of its programs, TAFE is the largest provider of further education to people with disabilities (Barker 1995). Small institutions, small class size and the clarity of learning outcomes in a competency-based education and training system also attract students rehabilitating from psychiatric disability to VET courses.

Literature review: Previous research in the area

There have been numerous studies conducted on the impact various mental disorders have on aspects of learning. The empirical evidence overwhelmingly links psychiatric disorders with impaired cognitive functioning (Dobson & Kendall [eds] 1993; Housel & Hickey 1993; Crowe 1998). Disorders like schizophrenia and affective disorders, including depression and anxiety, have been associated with impaired memory functioning, especially short-term memory and verbal learning (Beatty et al. 1993; McAllister 1981). Additionally, schizophrenia has been correlated with impaired problem-solving skills, critical thinking (King & Phillips 1985) and inductive reasoning (John & Dodgson 1994). Anti-psychotic medication has been found to further impair cognitive functioning (Sweeney et al. 1991; Chaban 1996).

In summary, common limitations due to psychiatric disability include:

- ♦ *thinking* (including concentration, focus, fear of failure, memory, critical thinking and argumentation)
- ♦ *behaviour* (hyperactivity, impulsiveness, motivation, fluctuating energy levels, inappropriate responses in class or with peers, isolation)
- ♦ *perception of reality* (hearing voices, depersonalising)
- ♦ *affects* (anxiety, panic, phobias, frustration, anger, depression, paranoia, shame and mania)
- ♦ *judgement and insight* (psychosocial and self-reflective skill deficits which hinder ability to seek assistance or make optimal decisions)

Cognitive and physiological side effects of medication also impair learning, and change-over or withdrawal of medication during critical study periods is deleterious to effective study. Effects of medication include: restlessness, drowsiness, fatigue, noticeable physical symptoms, memory lapses and blurred vision. It is also worth noting that the nature of study is stressful (including exams, deadlines, cut-offs, and the normal distribution curve requirements of assessment which mean a proportion of any student cohort will fail).

Poor self-esteem and self-cohesion impair confidence to study and interact (socially and in the classroom). Also impaired are insight and judgement, planning and self-organisation, higher executive functions, problem-solving and coping mechanisms. Problems forming and maintaining relations with others are a concern in group academic tasks and classroom contexts as well as in non-academic contexts. Students are at risk of paranoia, bullying, ostracism, loneliness and failure at group tasks. Students also miss out on opportunities for co-operative learning as well as developmental opportunities.

Clients with personality disorders tax the resources of the mental health system (Harris 1991) but are particularly difficult for educational institutions to deal with

without specialist advice. Sometimes personality disorders may mask the recognition of another clinical disorder such as depression.

Impact of psychiatric disability on learning

In reviewing the impact of psychiatric disabilities on learning, it is important to distinguish between responses to the mental *disorder* and responses to the *disability*, between cognitive symptoms and cognitive deficits. Cohen and Farkas (1996) also note the need to distinguish between treatment and rehabilitation. Cromwell and Spaulding (1978) distinguished between vulnerability-linked deficits and symptom-linked deficits. They described symptom-linked deficits as associated with presence of psychosis, and vulnerability-linked deficits present not only during psychotic phase but during premorbid and remitted states as well (a factor which has significance for the provision of accommodations to students). Cognitive symptoms have long been known (and been targets of treatment); they include thought disorder, hallucinations, and delusions. Cognitive deficits in schizophrenia include problems of attention, concentration and memory as well as impairments in abstraction and concept formation abilities and have only recently become targets of research and treatment (Stuve, Erickson & Spaulding 1996, p.10). They note that the mainstream view of schizophrenia today is that biological and environmental vulnerabilities interact over the course of development of the illness to produce complex changing patterns of development, and they conclude that it is increasingly clear that some of these impairments are neuropsychological. Stuve, Erickson & Spaulding (1996) hypothesise that conceptualisations and interventions already developed to address cognitive difficulties experienced by the aged and brain injured offer a useful resource for working with the chronically mentally ill.

Stuve, Erickson & Spaulding (1996) also report that the cognitive problems of Acquired Brain Injury (ABI) patients—which are also common to aged, alcohol-damaged and mentally ill patients—include: problems of attention and concentration, learning and memory, psychomotor speed and problem-solving abilities. Attention processes include not only relative differences in attentional capacity, but the ability to selectively attend to relevant stimuli, sustain focus when distracted, redirect attention or respond to multiple tasks. Learning and memory aspects include the ability to organise and store incoming information as well as accurately retrieve it on a later occasion; psychomotor speed involves simple reaction time but also the ability to respond optimally as tasks become more complex. Organisational, reasoning and problem-solving skills include abilities to establish, maintain and shift set, employ analogical, inductive and deductive reasoning, analyse complex stimuli and integrate information. It is also necessary to plan, organise and properly sequence appropriate responses; anticipate environmental and social responses; and monitor one's own performance by inhibiting inappropriate impulses and by self-correcting.

Impaired functioning as a result of psychiatric disability impacts in the following ways.

Cognitive functioning

Dobson and Kendall (1993) note the effects of emotional disorders on attentional bias, memory bias, interpretations of ambiguous stimuli and on judgement. Crowe (1996) found that fluency of verbal tasks was impaired in both

schizophrenic and depressed persons, with greater impairment in the executive/ frontal lobe functions of persons with schizophrenia.

Emotional functioning

Impairment in emotional functioning may also affect learning and coping with student life. Markham and Danke (1991), for example, found that a high level of anxiety has a deleterious effect on tasks which make a heavy demand on working memory. Docherty and Herbert (1997) have demonstrated a differentiated emotional reactivity in communication disturbances in persons with schizophrenia.

Psychological functioning

The motivational and self-efficacy variables were found by Brackney and Karabenick (1995) to be highly significant in academic performance by students with psychopathology, together with resource management as well as cognitive and metacognitive ones. Palombo (1996) differentiates the psychological and neuroregulatory impairments of persons with attention deficit hyperactivity disorder (ADHD) and their resulting needs.

Social functioning

Social impairments were found in persons with mental disorders in a number of studies. Starkey and Flannery (1997) reported that deficits in receiving and interpreting information from others caused confusion, anger and fear. Kazarian et al. (1997) found a wide range of socially inappropriate behaviours and relationship problems in adult psychiatric inpatients, such as verbal abuse, inappropriate approaches and conversation, and disturbing others.

A particular difficulty in analysing cognitive deficits in the context of tertiary education is that cognitive deficits may be subtle and not easily determinable. They may also be attributed to other causes, with students being labelled as lazy, difficult or unco-operative. Empirically, the relationship between psychiatric or mental disorders and outcomes in post-secondary education is yet to be firmly established (Brackney & Karabenick 1995) and this is further complicated by the heterogeneous nature of many disorders. The literature suggests, however, that students with psychiatric disabilities commonly experience difficulties in studying and learning and with negotiating the environment or culture of educational institutions. For example, Unger (1993) found that most students with a psychiatric disability identified learning as an area of difficulty in life-functioning. When asked to nominate challenges specific to a vocational setting, the majority of responses appeared to be either directly or indirectly related to studying. The results of Unger's study also suggest that students with psychiatric disabilities may need assistance not just with the actual task of learning, but with the ability to adjust and function within the broader culture and environment of a VET provider institution or a university.

The bio-psychosocial model of mental disorders

The field of mental disorders is still evolving and there are few absolute answers. There is an emerging consensus, however, that mental health is an interaction between the biological, psychological, social factors (Bloch & Singh 1997). Biologically, a number of studies show the neurological and genetic bases of

mental disorders. Nutrition, chemical environmental pollutants, other diseases, prenatal factors, sleeping patterns, substance intake, brain injury or tumours, neurotransmitter abnormalities and genetic predisposition have all been linked to development of mental disorders.

Psychological factors are strongly implicated in mental health, in terms of cognition, emotions, and their interaction, behaviour patterns, and self-structure (the ways the person organises his/her subjective experiences into coherent meaningful patterns). A healthy person is able to achieve an optimum balance between the maintenance of his or her self-structure, and openness to new forms of experience (Stolorow, Atwood & Brandchaft 1994). However, it is through rigid pathological self-structures, or underdeveloped self-structures with unfulfilled needs, that clinical mental disorders and personality disorders may arise.

The developmental perspective where early experiences of the child are formative of the psychological self (and brain) structures is important, and involves both social and intersubjective factors. These include the influences of others, such as early care-givers, teachers, family relations, peers, work colleagues and other people interacting with the person.

The inter-subjective perspective, where there is an interaction between the subjective (meaningful) worlds of both parties, is particularly useful in the post-secondary sector, because it is the subjective impact of relations between staff/students and students/students, that influences outcomes (Stolorow, Atwood & Brandchaft 1994). For example, when one person smiles, the other person may interpret the smile as contemptuous and withdraw or react. Some factors, such as a lack of personal/emotional support from others, helplessness, major loss of another person, humiliation, entrapment, abuse, neglect, a pattern of criticism or negative emotions from others may precipitate mental disorders. This is especially the case if self-esteem is low or insufficiently mature and the person is vulnerable.

A recently emerging element in this bio-psycho-social model is spirituality. Students with psychiatric disability may be more sensitive to: altered states of consciousness, alternative perspectives, sources of creativity and the fragility of well-being and life, and the consequent heightened sense of sharing between people with similar experiences. In addition, recovery can bring about a deeper sense of meaning and spirituality.

Models of learning support

The issue of learning support for students with psychiatric disability is relatively new in Australia, but internationally (particularly in the United States) it has been the focus of significant attention, prompted partly by legislation, but also by innovations in treatment. When reviewing these in an Australian context, it is important to differentiate between cognitive symptoms and cognitive deficits, as well as between primary and secondary (adjunct) support.

North America

North American experience suggests that the psychosocial rehabilitation model has emerged as an effective community-based alternative to traditional models for treating chronic mental illness (Anthony, Cohen & Farkas 1982), with a growing reliance on the use of educational approaches to supplement (and

sometimes replace) biomedical and psychodynamic methods. According to Ryglewicz (1989, p.69 in Stawar 1992), psycho-education is 'valid and generalisable and can provide guidelines for action'. Anthony, Cohen & Farkas (1982) suggest direct teaching of skills to clients is one of ten essential ingredients of psychiatric rehabilitation. They believe effective psychosocial rehabilitation requires formal teaching experience with teachers experienced in 'sequencing and individualising' skill lessons. The work of Unger and her colleagues at the Centre for Psychiatric Rehabilitation at Boston University has contributed significantly to an understanding of cognitive rehabilitation programs for students with psychiatric disabilities studying at tertiary institutions. Their project aimed to increase awareness of the mental health system and post-secondary educational settings of the efficacy of providing services for persons with psychiatric disabilities. They have developed:

- ❖ programs which utilise existing systems and which meet the expressed needs of students with psychiatric disabilities
- ❖ program models which can be replicated and described, and
- ❖ ongoing evaluation procedures

Moxley, Mowbray and Brown (1992) describe three general models of supported education programs (SEP).

- 1 *The self-contained classroom (which utilises an established structured precollege curriculum based on the college campus). This model has a strong vocational focus. Students may utilise the facilities and support programs of the education institution but they are not integrated into classes. Credit may or may not be available and it would be expected that these students move eventually into integrated classes.*
- 2 *The on-site model utilises existing on campus supports to make them more accessible. Students attend regular classes and receive credit for these. Support is provided by staff from the education institution (usually disability support staff and/or counselling staff).*
- 3 *The mobile supported education model is attached to an existing psychosocial or psychiatric rehabilitation unit. It provides support, symptom management and academic skill development through the use of mobile 'trouble shooters'. Students attend regular classes and receive credit with the main difference from the on-site model being that the support is provided by community-based mental health services.*

Mowbray and Brown (1992) note the need to accept that the resources will vary enormously across sites and that institutions must tailor 'state-of-the-art knowledge to local needs and adapt to local resources' (p.130).

They conclude that successful programs:

- 1 *bring together a strong and diverse planning coalition*
- 2 *plan coalition needs to understand supported education programs (SEP)*
- 3 *understand the needs of participants and rehabilitation processes*
- 4 *understand the policy, resource and administrative barriers, and*
- 5 *formulate values and priorities*

Britain

A variety of programs have been developed based on the needs of specific populations and the individual needs of client groups. Programs are generally

categorised as either discrete (specialist programs for students with disability including mental health problems) or mainstream opportunities (with additional support available). Many courses are available through outreach programs at organisations such as psychiatric units. Wertheimer and Ford (1994) note that while this offers an effective means of marketing courses to potential students, it does not facilitate integration into ordinary student life.

Australia

Very little work has been carried out in developing and implementing support models for people with mental health problems studying in Australian post-secondary educational institutions. The Baulkham Hills TAFE in New South Wales is an exception. In 1994-95 research was undertaken to trial five models of educational support for students with mental health problems (McIntyre, Wortley & Bonser 1994; McIntyre, Bonser & Jameson 1995).

The models included:

- a) *consultant support for teachers* (consultant help available for mainstream academic staff)
- b) *team teaching* (with a specialist teacher working along the mainstream staff to provide specialist curriculum support and teaching support)
- c) *tutorial assistance* (with up to 25% additional tutorial support available to students as concurrent support)
- d) *special class* (a non-mainstream grouping taught by subject specialists with a student teacher ratio of 8:1), and
- e) *flexible delivery* (with students enrolled in the Open Training and Education network instead of mainstream classes. Access to alternative delivery methods through the Individual Learning Centre was available on a concurrent support basis)

Results from these evaluations indicated that programs had different goals and reported outcomes differently. In all models, a significant proportion of persons attempting post-secondary education achieved success (success itself can be interpreted in ways outside academic success and progression rates; enhanced self-esteem and improved social skills for example).

At the University of Melbourne, the university administration has collaborated with a consumer-initiated group (Mental Awareness of Students on Campus—MASC) utilising a matrix management model, to provide a project worker to facilitate a peer-mentor volunteer program. The university has also provided a quiet space (office and a lounge area) for students with psychiatric disabilities and funded the part-time project worker. As a student-initiated project utilising matrix management principles, the program circumvents some of the issues associated with disclosure (students can access the support without disclosure). In addition to student support, a primary aim of the MASC project is enhanced staff and student awareness of mental health issues.

Issues of disclosure of disability

Unlike in the primary or secondary system, self-advocacy and disclosure are ultimately the responsibility of the student with disabilities, not the institution. Disclosure, or 'intended release of personal information by individuals regarding

their tastes, interests, work, money, education, attitude, opinions, body and personality' (Jourard & Lasakow 1958, p.56) is therefore a major issue. Lynch and Gussell (1995) suggest there are four conditions to disclosure:

- a) *relationship characteristics (a relationship appropriate for revealing)*
- b) *context characteristics (a context perceived to be appropriate)*
- c) *source characteristics (the student feels comfortable about revealing information)*
- d) *receiver characteristics (the receiver appears trustworthy)*

They describe the benefits of disclosure as follows:

- a) *accommodations—benefits which may also help other students in class (for example the lecturer using a microphone)*
- b) *disclosure may open up opportunities for students with disabilities (for example, extended exam time or more flexible deadlines for assignments)*
- c) *students will no longer have the stress of keeping the disability hidden*

Lynch and Gussell (1995) also express a number of concerns about disclosure.

- a) *Privacy boundaries such as self-esteem and sense of autonomy are dependent on having control of one's own private information.*
- b) *Hidden disabilities such as psychiatric disabilities, learning disabilities and AIDS have emotional ramifications. If students don't require the accommodations, it may be better not to disclose, rather than risk the prejudice which may arise from lack of understanding about their condition.*
- c) *In primary and secondary school, it is the school's responsibility to provide supports, in post-secondary, it is the individual's responsibility to request assistance. Not only may this be difficult for some students, often parents too, find it difficult to establish what their role should be. While family support remains vital to a student's success, tertiary institutions have few mechanisms to support parental input (O'Gorman, 1996).*
- d) *If students fail to disclose early, they may do so later when there is a problem and academic failure may be the prospect if they don't seek help.*
- e) *Negative feedback is a real possibility (students may risk prejudice, only to be refused accommodation or be offered a watered-down version).*
- f) *For many students, talking about one's disability can result in perceptions as helpless or sick.*

Lynch and Gussell add the following note of warning: they comment that the attitude that students with disability need help in all areas is potentially one of the most hazardous barriers for students with disabilities (Lynch & Gussell 1995, p.353).

Myths and reality

Issues of disclosure are closely tied to the risk of stigma which can arise from ignorance about mental illnesses. The *California Community College guide for students with psychological disabilities* (1991) juxtaposes the following list of myths and realities as an indication of the stigma facing many students. The list appears just as relevant in the Australian context.

There are a number of *myths* about students with mental illness or psychiatric disability.

- ❖ It doesn't exist in post-secondary education.
- ❖ Students with psychiatric disability are more likely to use more services than other disability groups.
- ❖ Students with psychiatric disability are more likely to be homeless and jobless.
- ❖ Students with psychiatric disability are more likely to be disruptive, even dangerous.
- ❖ Mental illness is contagious.
- ❖ Schizophrenics have split personalities.
- ❖ Mental illness = mental retardation.
- ❖ Providing services to students with mental illness compromises academic integrity.
- ❖ You can always 'tell' when a person has a psychiatric disability.

The *reality* about mental illness or psychiatric disability can be described in the following way.

- ❖ It is often a hidden disability.
- ❖ Mental illness manifests uniquely to each person.
- ❖ Limitations are *not* intellectual, although the illness can interfere with cognitive functions and the learning process.
- ❖ Low self-esteem and fear of a recurrence of illness are common.
- ❖ Persons with psychiatric disability are not especially dangerous.

Stigma of mental illness

Support in most educational institutions is generally dependent on disclosure. Not unreasonably, students look for reassurance that disclosure will not result in them being discriminated against, stigmatised or disparaged. There is clearly a conflict between confidentiality and the need to understand student needs. A common response is partial disclosure, in which disability staff are aware of the precise nature of the disability while academic departments are not.

Discussions with disability liaison officers suggest that disability staff recommend disclosure in circumstances such as:

- ❖ if side effects from illness and/or medication are obvious
- ❖ after a series of educational failures
- ❖ if attendance is a problem
- ❖ when alternative assessment is indicated
- ❖ if the student is at risk to self or others
- ❖ when communication or social skills are seriously impaired
- ❖ if the student's ability to stay cohesive is seriously impaired
- ❖ when the student is emotionally volatile
- ❖ if severe cognitive deficits are evident
- ❖ if behaviour or level of energy is unusual

Legislation dictates, however, that the onus is on institutions to create a safe and confidential environment for disclosure and that support must be provided whether the student discloses, or whether the mental illness is merely imputed.

Legal implications for policy

Federal and State disability legislation and the policies (see p.20) indicate a number of conditions relating to psychiatric disability:

- ❖ Accommodations should be provided unless unjustifiable hardship can be substantiated.
- ❖ There should be a consideration of the benefits as well as the costs of accommodations (for example, creativity in education, tolerance, affirmative action and accommodation of others in the future as well as the present).
- ❖ Course selection should not presume an employer's judgement of meeting the inherent requirements of the job.
- ❖ Selection cannot prescribe a level of wellness as a prerequisite, unless unjustifiable hardship can be clearly demonstrated.
- ❖ Time extensions such as double-time can be negotiated up-front.
- ❖ The disorder/illness must have ongoing impact in order to obtain accommodations.
- ❖ Institutions need to ensure that fieldwork placement should not place students where there is foreseeable risk of harm to self or others.
- ❖ In situations of threat to safety or fear, the student need not be accommodated; however, it is advisable to avoid liability and therefore do as much as possible to accommodate the student.
- ❖ Normal duty of care provisions apply in educational institutions (for example, support staff are expected to possess and utilise special skills and knowledge). Confidentiality can be broken when there is a perceived threat to self or others.

The Disability Discrimination Act (1992) confers accommodations to students with disabilities unless it would constitute 'unjustifiable hardship'.

Accommodations which allow the student to meet requirements and enjoy benefits must be provided in the most dignified, appropriate and least onerous manner possible.

The Mental Health Legal Centre in Victoria (1997), in 'Comments on discussion paper—DDA disability standards in education', suggests that the DDA prohibits:

- ❖ direct discrimination (DD) (treating someone less favourably because of their disability)
- ❖ indirect discrimination (ID) (requirements, conditions or practices which, though they may appear neutral, have an unfavourable impact on people with disabilities)
- ❖ discrimination on the grounds of a manifestation of a disability in some circumstances (DM)
- ❖ denial or limiting of access to benefits (LAB)
- ❖ subjecting the student to any other detriment (SD)
- ❖ harassment (HR)

The following section indicates the implications of the DDA for post-secondary institutions.

Situations that may arise at selection that may be discriminatory

The following situations may arise at selection and are discriminatory:

- ❖ requirements as to previous educational or work history or performance (ID)
- ❖ requirements as to demeanour, communication skills or how a person relates to others (ID)
- ❖ prejudicial or inaccurate assumptions about the disability's impact (SD)
- ❖ mistrust or denial of credibility (SD)
- ❖ behaviour requirements (ID)
- ❖ requirements as to participation in certain sorts of activities, e.g. social activities (ID)
- ❖ a judgement that the student will not be able to meet the inherent requirements of the job later on (only employers can make this judgement)

Suggested appropriate accommodations are as follows:

- ❖ accommodations to pre-requisites for admission
- ❖ accommodations as to expectations or requirements as to how someone will interact, communicate or behave
- ❖ accommodations to Student Code of Behaviour, student responsibilities or disciplinary requirements
- ❖ accommodations based on a person's individual needs due to their disability, not assumptions about a disability affecting all people the same way

Course-related aspects that may be discriminatory

Potential discrimination based on course issues include the following requirements:

- ❖ requirement that a course or subject be completed within a particular time-frame (ID)
- ❖ requirement that a certain number of classes be attended during course (ID)
- ❖ requirement that classes be attended at a certain time of day (for example, in the morning when a person may be particularly affected by medication) (ID)
- ❖ requirements that a student study a course or subject on campus as opposed to flexible delivery (correspondence) (ID)
- ❖ requirement that a particular load of study be undertaken (ID)
- ❖ restriction as to when the student can defer (ID)

Suggested accommodations include:

- ❖ flexibility in load of study
- ❖ waiving or adjusting attendance requirements
- ❖ flexibility as to overall period of time which may be taken to complete a course or subject
- ❖ availability of flexible delivery (for example, correspondence)
- ❖ respite periods during courses or subjects which allow students to return and complete, rather than recommence
- ❖ flexibility in timetables, priority choice for disabled students

Administrative procedures that may be discriminatory

The following administrative requirements may be discriminatory:

- ❖ requirement that a person meet the usual administrative procedures associated with such matters as enrolment, withdrawal, deferment or application for special consideration (ID)
- ❖ requirement that a person will only be eligible for special consideration if they initiate the application process themselves by a certain time, e.g. three days after the assessment occurred (ID)
- ❖ non-reversal of results (ID)

Suggested appropriate accommodations include:

- ❖ staff may initiate administrative procedures if previously authorised by the student
- ❖ accepting late or retrospective applications
- ❖ deletion or adjustment of results recorded if the results are a product of discrimination

Assessment-related practices which may be discriminatory

Discriminatory practices related to assessment include the following requirements:

- ❖ that assessment in a particular subject take a particular form, for example oral presentation or exam (ID)
- ❖ that assessment take place at a particular time or venue (ID)
- ❖ that assessment meet criteria such as spelling and structure (ID)

Suggested appropriate accommodations include:

- ❖ flexibility as to form, time, or venue for assessment
- ❖ adjustment of assessment criteria such as spelling, structure, or other aspects of performance which enhance but not necessarily constitute academic understanding

Discrimination in services and benefits

The following practices are discriminatory:

- ❖ limiting access to services which facilitate study or support, such as computers, libraries, counselling services, notetaking (LAB)
- ❖ limiting access to participation in arts, sporting, social or other activities (LAB)
- ❖ lack of respite spaces (LAB)
- ❖ lack of car parking spaces when required (LAB)

Appropriate accommodations include:

- ❖ provision of counselling and support services (on an ongoing basis)
- ❖ provision of respite spaces
- ❖ access to computers, libraries
- ❖ provision of car parking spaces
- ❖ provision of notetaking

- ❖ accommodations which put the absent student in the position they would have been if they had been able to attend classes, for example providing notetakers not just tapes

Treatment by others that may be discriminatory

The following practices are discriminatory:

- ❖ treating the student unfavourably because of the way psychiatric disability manifests, such as the way they behave, appear physically, make eye contact, communicate or relate to others (DM)
- ❖ the student is excessively supervised or work excessively scrutinised (SD) and (DD)
- ❖ the student is relegated to menial or unsatisfying tasks (SD) and (DD)
- ❖ the student is isolated, excluded or alienated (SD) and (DD)
- ❖ the student is ridiculed, denied or vilified by other students or staff (SD) and (DD)
- ❖ the student is harassed by staff's use of demeaning, stigmatising or vilifying language related to psychiatric disability, even if not specifically directed or in relation to the student (HR)

Appropriate accommodations include:

- ❖ treat the student fairly and favourably even if the psychiatric disability is manifested
- ❖ adjust disciplinary and behavioural requirements
- ❖ include student in class activities or facilitate acceptance
- ❖ protect student from other students' or staff's derisory comments or language

The research was conducted with a sample of consenting students who have identified themselves as having a psychiatric disability. Other stakeholders whose views were canvassed included institute staff and community and industry groups in a number of metropolitan and rural institutions Australia-wide. Discussions took place with a number of post-secondary educational providers to secure their involvement in the project (see appendix 1 for a complete list).

Stage 1: Literature search

The literature search facilitated a deeper understanding of the issues facing the target group (including: definition, disclosure, rights and responsibilities, special needs groups such as international students, and legal implications) and a review of non-confidential institute data (including policy documentation and existing programs). The literature search also provided data on support programs conducted internationally (a preliminary search indicates little evidence of learning support programs in Australian educational institutions although there is some research into workplace support programs). There is a large body of literature on cognitive rehabilitation programs developed for aged and acquired brain injury (ABI) populations but which have recently been applied for use with the target group in a number of North American educational institutions (Stawar 1992; Cohen & Farkas 1996). The literature describing the range of supported education programs (SEP) developed over the last decade as a response to problems arising from deinstitutionalisation policies was also reviewed.

Stage 2: Initial data collection

The initial data collection involved:

- a) in-depth structured interviews with 95 key stakeholders from the target group (students and prospective students who acknowledged a psychiatric disability; teaching and support staff in the VET and higher education [HE] sectors, mental health services, community psychiatric disability support groups including advocacy organisations, and consumer groups)
- b) telephone interviews with interstate representatives and internet link with international institutions
- c) collection of policy documents and legislative information from post-secondary institutions and other relevant policymaking bodies in Victoria and nationally

Notes were taken in all interviews and the information transferred to a Word document to facilitate analysis. At key interviews, two people were routinely present and notes were a compilation of perceptions of both interviewers.

Policy documents and legislation were summarised, taking account of the following:

- ❖ State and federal legislation
- ❖ VET, HE and health policies
- ❖ intra-institutional policies
- ❖ existing program evaluation documentation

Stage 3: Main data collection

a) Focus groups of 6–8 participants

- ❖ groups composed of disability support staff at Victorian TAFE and higher educational institutions (two groups set up, one for metropolitan, one for regional)
- ❖ groups composed of support staff (counsellors) at Victorian institutions including both metropolitan and regional institutions (two groups set up, one for TAFE and one for HE institutions)
- ❖ teaching staff, counsellors and disability liaison officers (DLOs) in TAFE and HE institutions in Melbourne, Brisbane, Adelaide and Sydney
- ❖ teaching staff in TAFE (one group in Melbourne, two in country Victoria)
- ❖ the target group: students and prospective students, group to comprise students from both TAFE and HE. Composition to take account of age, course, nature and duration of psychiatric disability, socio-economic level (SEL), gender, ethnicity and geographic location (interviews with this group will be repeated as often as necessary utilising a hermeneutic cycle)
- ❖ community groups involved with support of the target group (Richmond Fellowship, Schizophrenia Fellowship, Bromham Place)

The interviews were audio-taped and coded to preserve confidentiality. The tapes were transcribed and the resulting data kept secure. Risk minimisation procedures were put in place (emergency telephone numbers were obtained prior to the interviews; a qualified counsellor was available at each session; debriefing was available). Transcriptions were put into a Word document to facilitate analysis.

b) Instrument development

Data collected from interviews with key stakeholders and focus group discussions were grouped into themes or categories on the basis of key words and phrases. Findings from this analysis formed the basis of a series of questionnaires targetting the key stakeholder groups. The surveys asked questions and presented views considered important by mental health workers, students, support staff, teaching staff and management. The questionnaires utilised a 5-point Likert Scale (strongly disagree to strongly agree) and were distributed to:

- ❖ students from the target group. The survey was sent to disability liaison officers at all Australian TAFE institutions and universities for distribution to interested clients
- ❖ teaching, support (disability officers, learning support, counselling) and administrative staff (decision-makers as well as front-of-house staff) in all

university and TAFE institutions in Australian States and Territories, two Victorian Skillshare VET providers, and several private providers

- ♦ prospective students who were accessed by sending survey forms to community groups and mental health organisations such as Bromham Place, Schizophrenia Fellowship and EPPIC

c) Analysis of questionnaire data

Survey forms were coded to ensure anonymity of participants but codes enabled differences to be analysed:

- ♦ between States
- ♦ between post-secondary sectors
- ♦ between prospective and current students
- ♦ between academic staff, counsellors, DLOs, administrative staff and management

The survey questionnaire presented a series of statements for response (either by ticking a box or by circling a number on a 5-point Likert scale). There was also opportunity for open-ended comment.

The data was analysed using SPSS and aimed to provide student, staff and management perspectives on:

- ♦ range of psychiatric disabilities
- ♦ attitude to study
- ♦ effect of mental disorder on learning
- ♦ perception of appropriateness and extent of existing services
- ♦ preferred learning support methods
- ♦ views on disclosure
- ♦ effect of medication

Demographic information was collected on the following aspects of the sample:

- ♦ education sector (TAFE, private VET provider and HE)
- ♦ State or Territory
- ♦ gender
- ♦ age
- ♦ course
- ♦ time elapsed since diagnosis
- ♦ role (student, prospective student, disability officer, teacher, counsellor, learning skills advisor, administration officer, medical officer, manager)

An 'other' category covered atypical responses.

Open-ended comments were transferred to a Word document and discussed under the existing themes, with sub-categories developed based on key words and phrases. Sample quotations were used to encapsulate key views.

Limitations of the sample

The sample is, of necessity, biased. Student respondents to the survey will have disclosed their disability (and are therefore comfortable enough with their condition to respond to questioning). Staff respondents (particularly teaching

staff) will have particular interest in the area of mental health either because of negative or positive experiences. In all cases they are unlikely to be representative of the general student/staff population. The findings, therefore, relate to the views of only one section of the target group. The complexity and heterogeneity of the group 'students with psychiatric disability' is acknowledged, but has not been addressed in terms of project sample. In many ways this reflects an underlying problem of providing support to the target group; support is contingent on disclosure of disability and, in this sense, a sample which reflects the views of students who have disclosed must be accepted.

Stage 4: Consultation and validation

Part of an acknowledgement of the complexity of the issues involved in providing learning support to students with psychiatric disabilities involved acknowledging the need to consult widely, both with consumers, consumer support groups and staff at educational institutions.

An issues paper noting conclusions from the analysis above was circulated for comment amongst DLOs and counsellors at approximately 45 TAFE institutions, 30 Victorian and 15 interstate. Two feedback sessions were held in Melbourne with representatives from consumer groups, educational institutions and student groups.

A reference group with representation from consumer groups, consumers, academic staff, support staff and mental health authorities was available for feedback at all stages of the project and provided direct feedback on the issues paper.

Research limitations

The nature of the research area imposed a number of limitations on the research outcomes:

- a) The heterogeneous nature of psychiatric disability in terms of the range of disabilities and the differential effects on functioning is subsumed under general, legislation-based definitions. The focus of this study is not on psychiatric disability in general, but how psychiatric disability impacts on learning and adapting to a post-secondary environment.
- b) The students who form part of focus group discussions and the majority of those filling in survey forms were students who had disclosed to their institutions (and were therefore on the mailing lists of support staff at their educational institutions). It is, therefore, important to limit conclusions to this sub-group of the post-secondary population. Additionally, a common theme in initial discussions both with consumers and mental health authorities was the need to maintain an individualised focus, acknowledging not only the individual differences in learning style but the uniqueness of the effect of illness on each individual.
- c) The heterogeneous nature of institutions was also a factor, with responses varying both within institutions and between institutions within the two education sectors (HE and VET).

Emerging themes

Analysis of initial interview and focus group data elicited the following themes. The matrix provides sample comments (*italicised comments are quotations from interview data*).

Themes	Stakeholders		
	Students	Support staff	Management
Definition and terminology	Prefer non-problematising terms like mental health issues.	Use psychiatric disability—DLO's. Use mental health or psychological problems—counsellors.	<i>Lack of agreement on terminology is confusing for administrators.</i> Use legislative definitions such as psychiatric disability or impairments.
Extent of mental disorder on campus	Current figures an underestimate because of non-disclosure.	Support staff work with those who have disclosed—approx 20% of disability population.	Affected by definition, disclosure and data collection measures.
Diversity not difference	<i>We have our life experience to contribute.</i>	Unfortunate focus on deficits rather than acknowledgement of benefits of embracing tolerance.	Increasing awareness of need to take account of diverse student needs. Higher profile of equity because of policy and legislative changes.
Myths and reality—towards understanding of mental disorder	<i>Treat us like individual people with individual needs not cases or diagnoses.</i>	Many expressed concern about lack of training for staff.	Need for enhanced awareness of issues.
Issues of disclosure	<i>Risk of stigma is too great; is a personal decision.</i>	Conflict between confidentiality and need to understand student needs.	<i>A need to balance confidentiality and intervention planning.</i>
Stigma	<i>It's hard to fight what's not verbally communicated.</i>	Affects disclosure rates.	Linked to intolerance of difference.
Heterogeneous nature of the disability	Want to be seen as individuals, not stereotypes; recognise strengths.	<i>Impairments vary significantly between individuals.</i>	Need for guidelines.
Disruptive behaviour	Staff too judgemental.	Feel inadequately prepared; challenging nature of some disorders e.g. personality disorder.	Concern about effect of behaviour on staff; uncertainty about disciplinary measures.

Themes	Stakeholders		
	Students	Support staff	Management
Lower self-esteem and personal functioning	Lack of confidence, vulnerability. <i>The worst treatment was from other students.</i>	Impairs academic functioning, motivation and interpersonal relations.	Transition issues; intensive nature of needs stretches resources.
Systemic interventions	Need for extensions, extra time; course inflexibility.	Less clear about appropriate accommodations.	<i>Educational support issues should not be confused with treatment.</i>
Case management	Want one person to talk to, not tell their story repeatedly.	Unclear as to who should be responsible; both DLO and counsellors are available.	Useful as an accommodation; need to explore use of psychiatric consultants.
Supported education programs	<i>Need a supportive environment all the way through; better to be a student than a patient.</i>	Should have bridging programs attached to post-secondary education not mental health organisations; needs co-ordination.	Explore bridging programs.
Implications for policy	Want increased flexibility of course length, curriculum modification etc.	Need for intra- and inter-institutional consistency.	Need for greater awareness about policy.
Staff training	Staff need more training.	Staff need more training and clinical consultation.	Staff need more training.
Legal aspects	Afraid of being discriminated against; suffer until decision to litigate.	Uncertainty amongst staff about duty of care, discrimination, confidentiality etc.	Concern about issues of selection; work placement responsibilities; litigation.
Funding implications	Need to spend more on this disability group.	Uncertainty about how funding is best spent or obtained, e.g. who would fund bridging programs?	Fear of litigation; tight budgets.

Results

Three separate surveys (student, prospective student and staff) were developed based on the findings of focus groups and interviews held with all stakeholders. Student and staff surveys were sent to universities and TAFEs in all States and Territories of Australia. The prospective student survey was sent to selected mental health organisations in Victoria only.

Stakeholders were from both the university and the VET sectors and included: students (with and without experience of mental illness), administrators (management and front-of-house staff), teaching staff and support staff (disability liaison officers, counsellors, study skills advisors, campus medical staff).

The response rate (based on percentage of surveys sent out) was: students (10%), prospective students (26%), staff (43%).

Student sample (demographics)

Where were the students from?

The survey was sent to all universities and TAFE institutions in all States and Territories of Australia. In each institution, the disability liaison officer was contacted by letter and asked to distribute the surveys to students they thought would be interested in contributing. Of 115 student respondents, 32 per cent were from the VET sector and 68 per cent from the university sector.

Most respondents were from Victoria and New South Wales (figure 1).

Figure 1: Student sample—State and educational sector

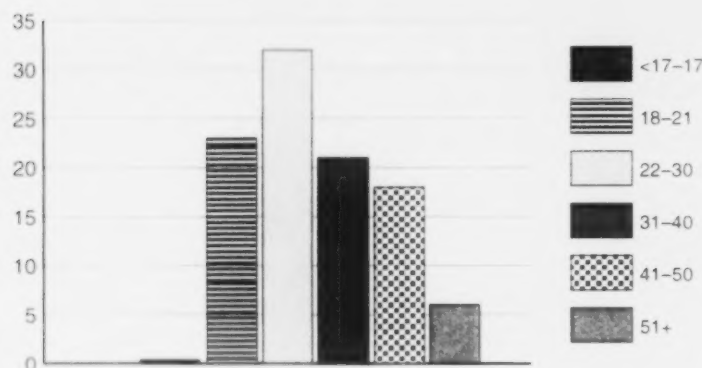


Age and educational background of the students who responded

The surveys were to be distributed to any interested student regardless of year level or course. Because the surveys were distributed by the DLO, it was assumed that respondents would have disclosed their illness.

As indicated in figure 2, the majority of respondents ($n=115$) were not school leavers; 45 per cent of respondents were 30 years or older (24% were over 41).

Figure 2: Student sample—age



The majority of students (60%) were full time, with a significant number of part-time (30%) and off-campus (10%) students. While there were a number of first-year students (35%), the majority were later year students (50%). A number of students indicated they were undertaking university or TAFE study (13%).

Gender and language background

Almost all students (97%) came from an English-speaking background with the majority (63%) being female.

Duration of mental disorder and use of treatment

Most students had only recently been diagnosed (62% within the last five years), with table 4 indicating the period of time elapsed since diagnosis.

Most students (67%) had taken time out because of their mental disorder and 75 per cent were on medication (indicating that they had taken medication in the last week). Most respondents (78%) were currently seeing a psychiatrist. In the majority of cases (74%), the original diagnosis was made by a psychiatrist (with 10% of students diagnosed by a psychologist and 15% by a general practitioner).

Table 4: Period of time since diagnosis

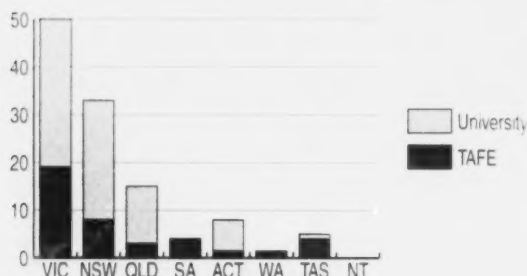
Period of diagnosis (% of sample)	Student % n = 115
< 1 year	17
1-5 years	45
6-10 years	19
>10 years	19

Staff sample (demographics)

The staff survey was sent to all universities and TAFE institutions in all States and Territories of Australia (three other Victorian VET providers were also surveyed). In each institution, the disability liaison officer was contacted by letter and asked to (a) respond to the survey themselves and (b) to distribute it to other staff (teachers, managers, counsellors, study skills advisors and other staff they thought would be interested in contributing). Of 257 staff respondents, 49 per cent were from the VET sector and 51 per cent from the university sector.

Figure 3 indicates geographic location of staff respondents. While there is representation from all States and Territories, the greatest number of respondents are from the eastern States, particularly New South Wales and Victoria.

Figure 3: Staff sample—State/Territory



Responses were received from most of the DLOs contacted (a total of 47). The largest group of respondents comprised counsellors (79) and teachers (66). There were a number of responses from senior managers (19) including deans and heads of schools and departments.

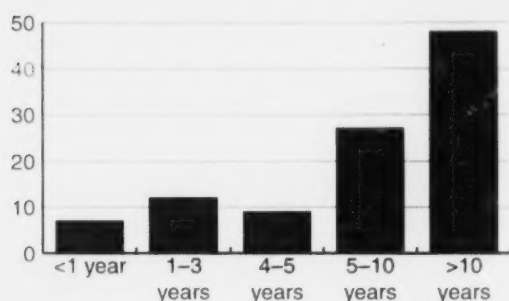
Figure 4: Staff sample—role (number of respondents)



Note: DLO = disability liaison officer; EEO = equal employment officer

Most of the staff who responded had been working in post-secondary education for more than five years (see figure 5).

Figure 5: Staff experience (number of respondents)



Prospective students (demographics)

A small number ($n=25$) of prospective students were surveyed through a number of consumer groups. Most were from Victoria with a small number (12%) from New South Wales and South Australia; reflecting the gender pattern of the larger, current student group, 72 per cent were female. As with the current student group, the prospective students are more likely to be mature-age students, with 72 per cent over age 31.

A number of prospective students (55%) had studied before but had deferred study because of their illness. Table 5 indicates the prior education undertaken by the group.

Table 5: Prospective students (previous study).

Previous study	% (n= 25)
Year 10 and below	28
Commenced VCE (but did not complete)	11
Completed final year of school	6
TAFE course	22
University course	33

Note: VCE = Victorian Certificate of Education

Despite the fact a third of this group had previously studied in university courses, the preferred course of study was primarily the vocational education and training sector with 57 per cent nominating TAFE courses and an additional 6 per cent nominating other VET courses. Prospective students overwhelmingly nominated part-time study as their preferred option (61%).

Nature of mental disorders

Both students and staff were asked to report on the nature of mental disorders; students were asked to nominate their own condition (based on DSM IV categories) while staff were asked to report on disorders they were aware their students had experienced. Figure 7 indicates the range of disorders experienced by the student sample, while figure 8 indicates the range of disorders staff note that students they have been working with have experienced.

Figure 6: Prospective students (preferred method of study)



Major depression is mentioned by the largest group of students, followed by bipolar and panic disorder. Schizophrenia and post-traumatic stress are also mentioned by a number of students.

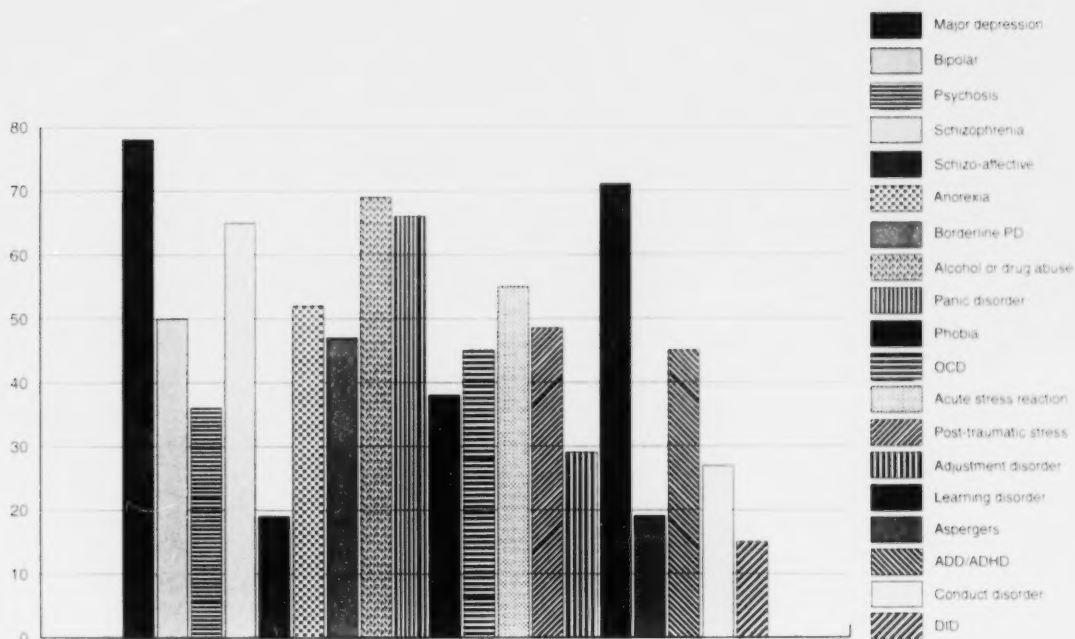
The disorders most often mentioned by teaching staff were major depression, schizophrenia, alcohol and drug abuse, learning disorder and panic disorder. Focus group discussion with teaching staff had highlighted confusion as to what constituted a psychiatric disorder. Central to this confusion was the perception that psychiatric disability (or mental illness) was probably a cluster of behaviours at one end of a continuum; characterised by inability to cope, disturbed and disturbing behaviour and an apparent requirement for medical attention. At the other end of the continuum were behaviour and feelings associated with the ability to meet the demands of everyday life and, in this case, academic life. The flatter pattern of disorders evident in figure 8 reflects the wider range of disorders mentioned by counsellors and DLOs as coming within their experience in working with students.

Figure 7: Nature of disorder (as indicated by students)



Note: PD = panic disorder; OCD = obsessive compulsive disorder; ADD = attention deficit disorder; ADHD = attention deficit hyperactivity disorder; DID = dissociative identity disorder

Figure 8: Nature of disorder (as perceived by staff)



The staff sample (n=257) was considerably larger than the student sample (n=115). However, the pattern of results is similar, with major depression, bipolar and schizophrenia being the major categories.

Figure 9: Nature of disorder (staff/student comparison)

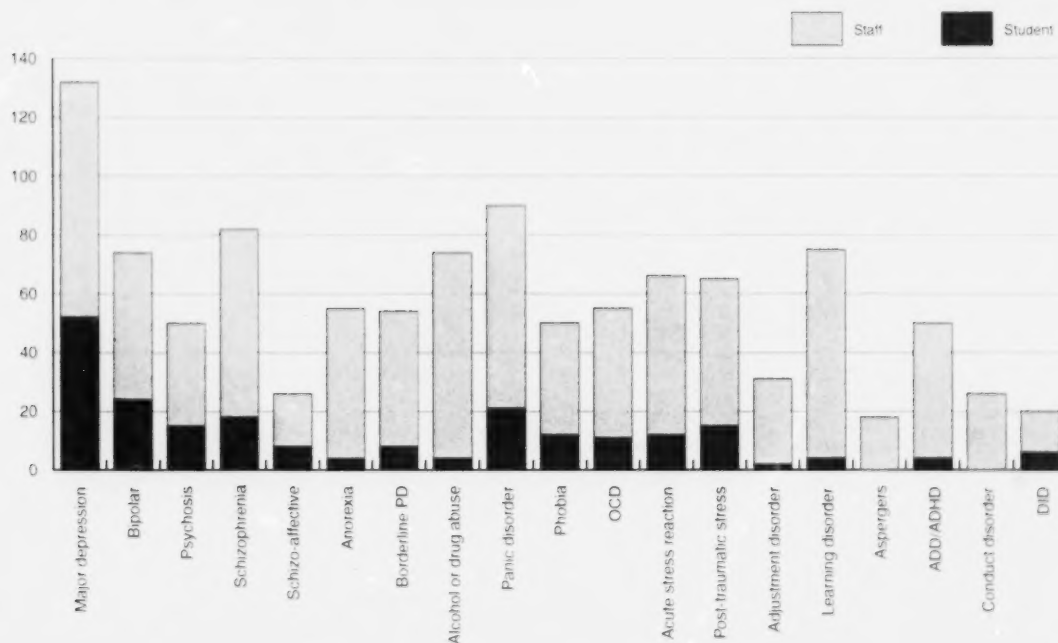


Figure 9 provides a staff/student comparison, and while the number of reported incidences of an illness is much greater in the staff sample (reflecting the greater number of responses), staff and student reports of particular disorders reflect similar patterns of incidence. Table 4 shows a comparison in disorders reported by staff in TAFE and university student populations surveyed. The inherent bias of the sample makes it unwise to draw other than broad conclusions about the range and numbers of mental health issues experienced by students in the post-secondary sector.

Table 6 indicates differences in the nature of disorders experienced by VET and higher education students as reported by students. The pattern is remarkably similar.

Table 6: Nature of mental disorder (TAFE/higher education)

Diagnosis	University %	TAFE %
Major depression	23%	27%
Bipolar	11%	12%
Psychosis	7%	5%
Schizophrenia	7%	6%
Schizo-affective	4%	2%
Anorexia	2%	3%
Borderline PD	4%	6%
Alcohol or drug abuse	2%	2%
Panic disorder	10%	11%
Phobia	5%	5%
Obsessive compulsive	5%	5%
Acute stress reaction	6%	5%
Post-traumatic stress	7%	3%
Adjustment disorder	1%	1%
Learning disorder	2%	2%
Aspergers	0%	0%
ADD/ADHD	2%	3%
Conduct disorder	0%	0%
DID	3%	4%
Number of times a disorder indicated	n= 143	n= 84

Note: PD = panic disorder; OCD = obsessive compulsive disorder; ADD = attention deficit disorder; ADHD = attention deficit hyperactivity disorder; DID = disassociative identity disorder

Student views on studying and adjustment to the student role

Students were asked to circle a number corresponding to their views on an issue as per the following legend.

1 Strongly agree 2 Agree 3 Undecided 4 Disagree 5 Strongly disagree

Table 7: Student views on studying

Student view on studying	student n = 115	prosp stdt n = 25
I would get/get satisfaction from studying.	1.8 (SD .965)	1.6 (SD .608)
I would like/like being a student.	1.8 (SD .986)	2.1 (SD .832)
After a while, I lose sight of my goals.	2.9 (SD 1.269)	3.5 (SD 1.25)
I lack the drive to get my work done.	3.1 (1.251)	3.6 (1.04)
I find it hard to get going on anything important.	2.8 (1.212)	3.4 (SD 1.10)
I have a clear sense of where my life is going.	3.1 (3.877)	2.6 (1.20)
Studying at university/TAFE is what I expected.	2.4 (SD 1.051)	na
I worked as hard as I could in 1st semester.	2.0 (SD 1.127)	na
I am focussed on the direction I want my life to go in.	3.0 (SD 3.877)	na
In my view, I have been 'together' most of the time this year.	3.2 (SD 1.316)	na
In my view I have what it takes to be a successful student.	2.4 (SD 1.056)	na
I was happy with my last semester/academic results.	2.63 (SD 1.29)	2.9 (SD 1.46)

Note: na = not applicable; SD = standard deviation; prosp stdt = prospective student

These findings generally confirm the focus group conclusions on expectations about study. Students enjoyed the student role and generally worked as hard as they could, but many were uncertain about their motivation and confidence. There was great divergence, however, in student opinions about the focus on 'the direction they want their life to go in', indicating one group that is very focussed on their goals and cohesive and another group that is not. A number of students expressed dissatisfaction with their last study results (24% unhappy and 20% unsure); however, most students (90%) had passed—24 per cent with honours and 28 per cent with above-average ratings. The correlation between performance and satisfaction with results is as expected, with 75 per cent of students who received a pass and 100 per cent of those who received a fail expressing dissatisfaction with their results.

Aspects of learning affected by mental health conditions (student perspective)

Table 8: Effect of mental health condition on study (student view)

Study aspect	TAFE (as %) n= 35	UNI (as %) n=77	TOTAL (as %) n=112
Concentration in class	63%	83%	77%
Motivation	51%	60%	57%
Reading skills	20%	30%	27%
Keeping to deadlines	34%	58%	51%
Remembering	60%	64%	63%
Regular class attendance	29%	53%	46%
Communicating	23%	34%	30%
Sitting for exams	46%	58%	54%
Confidence	54%	77%	70%
Concentration when studying	63%	85%	78%
Problem-solving	26%	30%	29%
Writing skills	20%	31%	28%
Adapting to college social life	29%	40%	37%
Getting organised	17%	40%	33%
Relating to people	40%	40%	40%
Explaining your needs	49%	52%	51%
Feeling at home on campus	31%	35%	34%

Major problems for most students were concentration (both when studying and when in class), confidence, motivation and memory. Perhaps reflecting the different teaching environments, problems which were of more concern to university than TAFE students include: keeping deadlines, class attendance, exams, getting organised and adapting to the social life of college. TAFE students tended to nominate a number of areas of concern, whereas university students were more polarised in their judgement about aspects of study which worried them. Other aspects of study mentioned by students as being affected by their mental health are reflected in the following student comments:

- ♦ I have difficulty getting to college.
- ♦ I worry about getting panic attacks.
- ♦ I feel very isolated sometimes.
- ♦ I don't have enough energy to get to class.
- ♦ I'm afraid of meeting prejudice when explaining difficulties.
- ♦ When I talk in class, I'm afraid I'll get a mental block so I tend to keep quiet.

- ❖ I have difficulty coping when I have a number of assessment tasks at once.
- ❖ I hate it when I'm not taken seriously.
- ❖ I have problems getting work in on time.

Aspects of learning affected by mental health conditions (staff perspective)

Table 9: Effect of mental health condition on study (staff and student comparison)

Study aspect	staff (as %) n=257	student (as %) n=112
Concentration in class	83%	77%
Motivation	77%	57%
Reading skills	50%	27%
Keeping to deadlines	80%	51%
Remembering	71%	63%
Regular class attendance	66%	46%
Communicating	67%	30%
Sitting for exams	68%	54%
Confidence	78%	70%
Concentration when studying	80%	78%
Problem-solving	64%	29%
Writing skills	52%	28%
Adapting to college social life	68%	37%
Getting organised	72%	33%
Relating to people	73%	40%
Explaining your needs	59%	51%
Feeling at home on campus	60%	34%

Table 9 indicates aspects of study mentioned by staff (cf. students) as being affected by mental illness. Staff were more likely to indicate aspects of post-secondary education affected by study (higher percentage of respondents nominating effects), but the patterns are similar in terms of degree of impact. The 'top 5' for staff and students is:

TOP 5 effects (student)

- 1 concentration in class (77%)
- 2 concentration when studying (78%)
- 3 confidence (70%)
- 4 remembering (63%)
- 5 motivation (57%)

Top 5 effects (staff)

- 1 concentration in class (83%)
- 2 concentration when studying (80%)
- 3 keeping to deadlines (80%)
- 4 confidence (78%)
- 5 motivation (77%)

What learning supports do students believe would be useful?

The list of support strategies was drawn from interviews with staff and students and from focus groups held with teaching and support staff and with current students. Table 10 indicates the degree of support for these strategies.

1 Strongly agree 2 Agree 3 Undecided 4 Disagree 5 Strongly disagree

Table 10: Learning support strategies (staff and student views)

Support strategy	mean student n = 115	mean prosp stdt n = 25	mean staff n = 256
A quiet space where students can go if they feel stressed	1.6 (SD .741)	1.9 (SD 1.03)	1.56 (SD .)
Staff to be available to talk to students (without appointment)	1.4 (SD .597)	1.67 (SD .724)	1.67 (SD .798)
More flexibility in course completion times	1.8 (SD 1.06)	2.0 (SD 1.0)	1.8 (SD .824)
Flexibility in assessment tasks	1.7 (SD .789)	1.9 (SD .917)	1.8 (SD .985)
Study skills help	2.1 (SD 1.06)	1.9 (SD .961)	1.4 (SD .565)
Additional tutorial assistance for specific subjects	2.1 (SD 1.17)	1.9 (SD .961)	1.7 (SD .778)
Availability of a peer mentor or 'study buddy'	2.3 (SD 1.14)	2.5 (SD 1.19)	2.1 (SD .875)
More flexibility in the student's course timetable	2.1 (SD .997)	2.5 (SD .915)	2.1 (SD .834)
More opportunity for the students to give consumer feedback to the university or TAFE	2.0 (SD .920)	2.1 (SD 1.03)	1.8 (SD .708)
Training for staff on mental health issues	1.6 (SD .895)	2.4 (SD 1.50)	
Case management by one staff member	1.6 (.803)	na (SD .855)	1.9

Note: na = not applicable; SD = standard deviation; prosp stdt = prospective student

Survey results support the views of focus group discussions with all student and staff respondents either agreeing or strongly agreeing that the suggested strategies are useful learning supports. It is interesting to note, however, that staff are strongly supportive of study skills help (mean 1.4) and additional content tutoring (mean 1.7) while students are slightly less in favour of these supports (mean of 2.1 for both study skills and additional tutoring). Availability of peer mentors and additional course flexibility are less favoured supports.

There is generally considerable agreement between staff and prospective student views. Interestingly, however, prospective students are less strongly in favour of additional training on mental health issues for staff than are current students and staff, perhaps because they do not yet have contact with educational staff.

Students were asked to rate the help they currently received in terms of (a) how well they felt staff understood their needs and (b) how adequately they felt they were assisted.

Student satisfaction with current support strategies

Students generally nominate a degree of both understanding and support (exceptions relate to the role of campus doctor and the role of the student association, and numbers in both these cases are too low to be significant). In TAFE institutions, counsellors are often multi-skilled, providing study, employment and financial advice in addition to psychological counselling.

The student perspective of difficulties experienced while undertaking study extended beyond the classroom and reflected concerns about the level and nature of support they received. The following comments indicate problems with the degree of support students found in their environment as well as the quality of support they received by staff.

These comments are a sample taken from the surveys; they have been selected to reflect the balance of views indicated by students.

- ♦ I felt like some kind of freak; this made it difficult to talk to people.
- ♦ I felt I would be judged by people so I would walk around campus trying not to be spotted in case they'd ask me why I hadn't handed in my work.
- ♦ Mental illness is different to physical disability, DLOs don't seem to know how to deal with us.
- ♦ Would have liked overheads and notes from the lecturer.
- ♦ For Austudy purposes you have to be full-time—this is hard.
- ♦ I didn't feel safe on campus.
- ♦ It's difficult to ask for help—I found it very stressful.
- ♦ Some teachers are ill-informed.
- ♦ Some students are *very* discouraging.
- ♦ Counsellor had no idea how to help with my panic attacks.
- ♦ Prejudice against mature-age students as well as mental illness.
- ♦ There is too much red tape.
- ♦ There aren't enough helpful people.
- ♦ I was harassed by fellow students.
- ♦ Counsellors and DLOs don't know how to deal with me.
- ♦ Counsellor treated me as if I was sick—because I said I might need on-campus treatment and my psychiatrist was some distance away.

The following table indicates the views of TAFE students on the help they received. Students were asked a) whether they felt staff 'understood their needs' and b) whether they felt staff met these needs.

1 Strongly agree 2 Agree 3 Undecided 4 Disagree 5 Strongly disagree

Table 11: Help received by TAFE students

TAFE	n=	%1	%2	%3	%4	%5	mean
Understood needs							
Course co-ordinator	25	40	32	16	8	4	2.04
Teacher	28	46	14	16	11	11	2.25
DLO	27	37	22	19	4	19	2.44
Counsellor	19	53	16	0	16	16	2.26
Study skills advisor	4	25	25	0	25	25	3.00
Student association	7	14	14	14	14	43	3.57
Administrator	10	40	10	20	0	30	2.70
Peers	17	18	35	18	18	12	2.71
Campus doctor	5*	0	20	0	0	80	4.40
Special needs advisor	4	0	50	0	0	50	3.50
Special needs tutor	4	25	50	25	0	0	2.00
Total	150						
Assisted me							
	n=	%1	%2	%3	%4	%5	mean
Course co-ordinator	27	37	19	22	11		2.41
Teacher	28	43	21	29	4	4	2.04
DLO	27	44	19	19	4	15	2.26
Counsellor	20	55	5	20	5	15	2.20
Student association	7	43	0	14	0	43	3.00
Study skills advisor	4	25	25	25	25	0	2.50
Administrator	10	30	30	10	10	20	2.60
Peers	17	12	35	18	24	12	2.88
Campus doctor	5	0	0	20	0	80	4.60
Special needs advisor	4	25	25	25	0	25	2.75
Special needs tutor	5	60	20	0	0	20	2.00
Total	154						

* It should be noted that campus doctors are generally not available on TAFE campuses.

University and VET sector students were also asked to give examples of the types of assistance they found useful. The following list reflects the range of student comments.

Examples of assistance received:

- ♦ extensions in assignments
- ♦ stress management techniques
- ♦ increased self-esteem
- ♦ encouragement
- ♦ referrals to other help
- ♦ advice on subject choice
- ♦ extra tuition
- ♦ sickbay when I was ill
- ♦ motivation
- ♦ help with notetaking
- ♦ help with time management
- ♦ advocacy
- ♦ room in the library
- ♦ peer support
(know I'm not the only one)
- ♦ help organising Austudy
- ♦ help deferring and with
fee remission/exemption
- ♦ additional time in exams
- ♦ help with course choice
- ♦ pep talks
- ♦ help with computer
- ♦ special exam conditions
- ♦ didn't rush my phone calls
- ♦ patience
- ♦ being treated like everyone else
- ♦ relaxation techniques
- ♦ representation from student union
- ♦ referrals
- ♦ being allowed to go part time
- ♦ study skills help
- ♦ visited me in hospital, I felt
cared about
- ♦ being listened to
- ♦ fellow students took notes during
absence

Interestingly, the majority of these suggestions relate to quality of care (additional understanding and time) rather than infrastructure costs.

A number of respondents (both staff and students) felt very strongly about the nature of the support they would find useful and wrote extensive notations to the survey. The nature of support required by students is indicated in the following sample of quotations.

What do TAFE students ask for?

This is a sample of comments received, selected to reflect the balance of student views.

- ♦ I want recognition that some of us march to the beat of a different drum; conforming to the beat of the conventional drumbeat can be overwhelmingly distressing.
- ♦ We need flexible attitudes towards exam times and course finishing times.
- ♦ I write slowly, I need a chance to catch up.
- ♦ I want to be treated as an intelligent human being not a backward child.
- ♦ We may be slower in catching on but we are not stupid!
- ♦ I want to be treated as a normal person (whatever that is!)—Not as disabled.
- ♦ I need feedback from teachers as to how I'm going (I tend to kid myself!).
- ♦ I would like to make other students and staff more aware of our needs—we are there amongst them.
- ♦ Study groups for external students would guard against isolation.
- ♦ I was almost through my course before I knew about the DLO.
- ♦ I sometimes feel isolated and unneeded and just need time to talk.

- ♦ The constant pressure for documentation makes me feel freakish and even more isolated.
- ♦ People are frightened when they deal with me—doesn't do a lot for my self-esteem.

What do university students ask for

- ♦ Alternative assessment (e.g. assignment instead of exams).
- ♦ More course flexibility (reduced load).
- ♦ More flexible attendance requirements.
- ♦ Support group on campus.
- ♦ Health and counselling staff who are more aware of needs of students with mental illness.
- ♦ Counsellors should be able to see students who have mental illness more often without feeling they are breaking the rules.
- ♦ Need a room where I can lie down or sit away from others.
- ♦ Staff need to know that some mental health problems are temporary and, with treatment, won't impact on study.
- ♦ Reduce the mystery—more training for staff!
- ♦ I found class discussions very helpful in developing my social skills.
- ♦ Extra help like tape recorders should not be sneered at and teachers should not get offensive if I have to repeat a question.
- ♦ Need better training of postgraduate supervisors.
- ♦ I need the opportunity to complete a semester when I've spent four weeks in hospital—extend deadlines and exams.
- ♦ Timetables/due dates/exams need to be more flexible.
- ♦ Access to software to use at home (getting to uni can be hard).
- ♦ More training—even among the well educated, myths about mental illness abound.
- ♦ Nowhere near enough funding—not enough staff; outdated equipment; lack of emotional support.
- ♦ Students should *not* have to educate academic staff or feel harassed to provide excessive documentation.
- ♦ To be able to deal with library by telephone—travel is difficult.
- ♦ Housing is a problem—home environment has exacerbated my problem—housing people on campus need training in dealing with people with special needs.

Both TAFE, other VET sector and university students expressed disappointment at the lack of understanding they receive from both staff and fellow students. In addition to a perceived need for awareness training, common concerns were: the need to provide documentation continuously, lack of flexibility of course structure, lack of emotional support and inflexible staffing arrangements. Most of the suggestions are not resource intensive, particularly when compared to support provided to other disability groups (e.g. sensory impaired). In many cases desired outcomes would be achieved through redirection of resources rather than additional resources.

Staff concerns: Disruptive behaviours

Disruptive behaviour was a concern nominated particularly by management, but also by teaching staff. It was seen as a major factor precluding successful study.

When asked to reflect (yes/no) on whether they had experienced disruptive behaviour from students they knew to have a mental illness, a number of staff respondents added additional comments. Table 12 gives examples of disruptive behaviours observed by staff in students with a mental illness. They are categorised into their impact on safety, classroom interaction and social interaction, although there may be overlap in some instances.

Table 12: Disruptive behaviours

Safety	Classroom interaction	Social interaction
suicide	verbalisation	personal hygiene
stalking	unrealistic expectations	extreme withdrawal
wandering	can't give a class paper	inappropriate sexual advances
threatening peers and staff	being demanding	ritualistic behaviour
self-harm	attention seeking	masturbating in public
fighting	domination of class	compulsive running
throwing things at people	temper tantrums	odd dress

A number of teaching staff in focus group discussion expressed concern about the safety of their students and themselves when dealing with the extreme behaviours of some students.

I've dealt with some students where I have been genuinely very nervous about being in their company, they've been so erratic that they've scared the life out of me and it's bothered me for a long time afterwards and even having to deal with them in a class situation . . . and it's quite alarming for the other students around them.

While it was acknowledged that disturbances leading to violence were a possible but uncommon event in the classroom, safety issues were a concern. A more common experience, however, was that disturbed classroom behaviour resulted in class members' inability to take in information and learn. One participant related how a class she had been teaching felt that a disturbed student's behaviour resulted in several class members gaining a lower mark than was expected. Such a scenario has a potential to lead to ostracism of the disturbed student, possibly compounding the problem.

. . . we've had situations before where a student's being so obnoxious to other students in the class that they feel that they can't concentrate on their studies and they've actually said they ended up only getting a pass and the student that was revolting ended up getting a credit . . . they had to leave because they couldn't tolerate his behaviour . . .

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Systemic support strategies

A number of staff and students during focus group discussions suggested case management and bridging schemes as possible responses to the need to co-ordinate support on an institutional level. The survey canvassed student/staff views on both these issues.

Case management as a support strategy

Both students (mean 1.6) and staff (mean 1.9) were strongly in favour of a case manager approach with each student's case managed by one staff member rather than dealing with several staff over the effect of their mental health on study. Figures 10–12 indicate student and staff views on who should take this role.

Not surprisingly (given that they are often already taking this role albeit often unacknowledged), disability liaison officers (DLOs) were the preferred choice for the role of case manager, nominated most often by both students and staff. Counsellors were also nominated by a number of students. There appeared to be considerably less agreement in the higher education sector than in the TAFE sector. This was probably compounded, in part, by the larger number of possible candidates for the role (most universities also had on-campus health services, a much rarer service in TAFE institutions). Collapsing the on-campus psychiatrist and psychiatric nurse categories, 22% of higher education students indicate that a person with specialist psychiatric training should take this role.

Figure 10: Preferred case manager—TAFE students



Note: DLO = disability liaison officer

Among staff respondents, DLOs and counsellors are again the preferred option for the case manager role. This can be partly attributed to representation of the group; counsellors were the largest group of respondents (31%; n=257) with DLOs forming 18 per cent and teachers 26 per cent. Most (89%) counsellors nominated counsellors, 68 per cent of DLOs nominated DLOs and 3 per cent of teachers nominated teachers.

Bridging schemes as a support strategy (staff views)

Staff were asked for their views on bridging schemes as a support strategy. The majority thought it a useful strategy.

Would you like to see bridging courses available for students with mental health problems?

Yes 84% Don't know 2% No 14%

There was less agreement on whether they thought students would attend such courses.

Do you think students with mental health problems would attend a preparation for study bridging course if it were available?

Yes 56% Don't know 9% No 27% Depends* 17%

* Reasons given for a 'depends' answer related to the following issues: availability (an issue for regional campuses), individual needs, quality and equity (should be available for everyone/should not have additional requirements).

Figure 11: Preferred case manager—higher education students

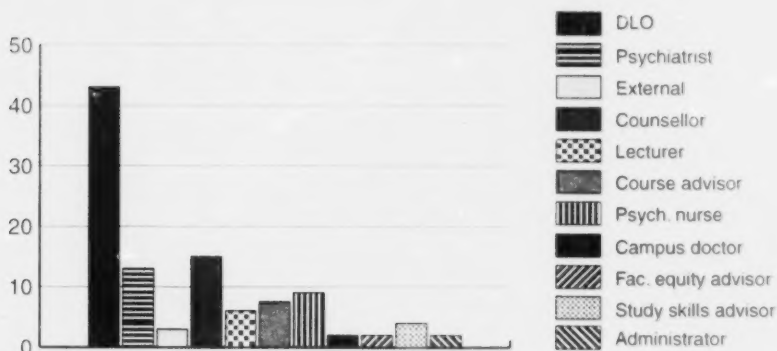
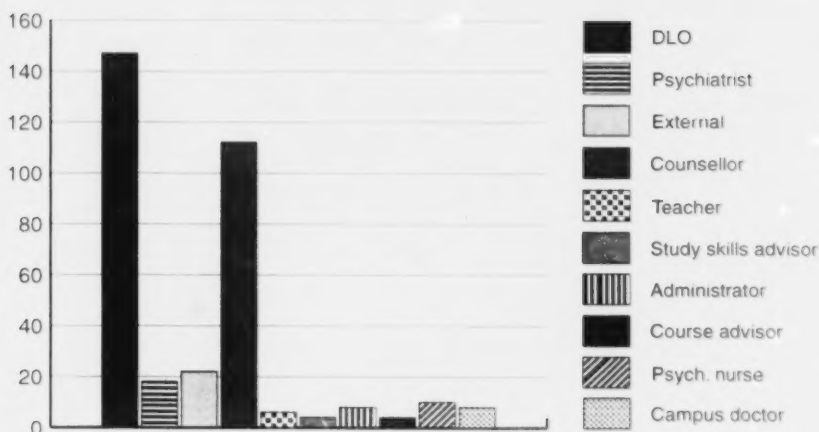


Figure 12: Preferred case manager—staff



Views on the ideal length of a bridging course varied from short courses to a full year program (see table 13).

Most respondents felt such courses should be run either jointly or in the education sector rather than the mental health sector.

Should bridging courses be run by:

educational institutions? (38%) mental health organisations? (5%) jointly? (31%)

Table 13: Bridging course duration (staff view)

Course duration	% in favour
1-5 days	25%
1-4 weeks	26%
5-10 weeks	9%
1 semester	6%
1 year	30%
Don't know	4%

Bridging schemes as a support strategy (student views)

Prospective students (n=25) were also asked their views on bridging schemes. In fact, 55 per cent of this sample had previously attended post-secondary education with all students who had not attended previous post-secondary study indicating interest in bridging schemes.

Would you attend a preparation for study bridging course if it were available?

Yes 50% No 44% Don't know 6%

Table 14: Bridging course duration (prospective student view)

Course duration	% in favour (n=25)
1-5 days	22%
1-4 weeks	50%
5-10 weeks	6%
1 semester	0%
1 year	6%
Don't know	16%

Issues of disclosure (staff and student perspectives)

Disclosure is a significant issue in the context of support, because while institutions are legally required to provide a non-discriminatory environment, the provision of support depends on a student's willingness to disclose their mental health impairment. Given that the student sample was accessed through the DLO in each institution approached, it was assumed that all respondents would have disclosed their illness to the university or TAFE in which they were enrolled (actual percentage indicating disclosure was 94%). Of these, 65 per cent indicated they would not advise others to disclose; many students indicated their regret in having disclosed, and detailed their reasons for this.

In fact, 68 per cent of students who disclosed indicated that they had requested special consideration, while 8 per cent indicated that they were unaware that special consideration was available.

Student views on disclosing mental health impairments

The following selection of comments reflects the balance of student views. Reasons have been grouped into the following categories: awareness raising, support, openness and safety.

Table 15: Student reasons for disclosure

Awareness raising	Support	Openness	Safety
To make the public more aware	to make use of available support	so that people understand when you're not yourself	is a mitigating circumstance for problems
Better support, understanding	to receive professional help	to be open	otherwise situation may worsen
I wish I didn't have this illness, but if I disclose, people will understand my plight	help in exams useful	sharing the problem relieves anxiety	if anything goes wrong, staff need to know who to contact
To help people understand mental illness	to get accommodations	takes the pressure off	fallback position
People need to acknowledge mental illness	to get support and help		
So others can get help	is worth the extra help		
To be understood better	more understanding, especially with deadlines		
	we need all the help we can get!		

A number of students indicated that they would only disclose under the following circumstances:

- ❖ only if help is available
- ❖ waited till after I had proved myself
- ❖ have to be pretty gutsy
- ❖ only to others with disability, otherwise would be an outcast
- ❖ only disclose to people who are caring and supportive
- ❖ only if it affects studying ability
- ❖ depends what you get out of it
- ❖ only when you need help

Students also indicated that they felt disclosure was a very individual decision ('it's not for everybody'; 'people have to make up their own mind', 'it would be different in different places').

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Table 16 groups student reasons not to disclose in the categories of: stigma, insufficient benefit and lack of understanding.

Table 16: Student reasons against disclosure

Stigma	Insufficient benefit	Lack of understanding
Prejudice and disadvantage	benefits not worth the cost	most don't understand
You'll be treated differently	it doesn't really help	teachers often ill informed
Labelled		I only met with misunderstanding
Led to harassment	some teachers felt obliged to make decisions for me, treated me differently	Not everyone understands
Leads to stigma		teachers don't understand, don't appreciate effects of illness
For fear of discrimination by ignorant people		some don't always respect confidentiality

A number of students indicated they felt there was insufficient understanding about mental illness and called for more staff training in the area of mental health issues.

Many students commented that they felt disclosure was a decision to be based on (a) the individual and (b) the institution, and that even then students should be careful who they disclosed to.

Staff views on disclosure

The issues of confidentiality and disclosure were discussed at length in focus groups. Disclosure in particular was an area that was very difficult for teaching staff to come to terms with. It was felt that in order to seek assistance, a degree of disclosure was necessary. However, it was equally felt that disclosure brought with it many potential disadvantages. Prominent among the disadvantages was the potential loss of confidentiality. On one of the regional campuses staff recognised the threat the smaller campus posed in relation to privacy. One participant described it as a 'fishbowl'. It was felt that being seen entering or leaving the counsellor's office was an admission of the existence of a problem. On some campuses with single purpose support services, an onlooker could identify the nature of the service user's problem by which service they accessed. This was seen as a major barrier to accessing support services. A second potential threat to confidentiality was the fact that if a student had a serious problem, was on medication or lived in a student residence, it would be difficult to maintain confidentiality over an extended period of time.

It was recognised by many of the participants in focus groups that disclosure would remain a problem so long as there was a stigma surrounding mental illness. This resulted in the participants (teaching staff) assuming psychiatric disability would be the least likely form of disability to be disclosed to the university. Relying on their own observations of a student's appearance or behaviour, it was felt that an 'at risk' student might have disagreeable body odour, may be unshowered or appear vague or perplexed. The participants felt

that students with difficulties were unlikely to seek help and therefore make a disclosure because often they were lacking insight into their situation.

Staff respondents (teaching and support staff) to the survey commented on the individual nature of the disclosure decision, but most (68%; n=257) felt it was in students' interest to disclose.

- ❖ 68% of staff respondents indicated they would advise students to disclose
- ❖ 13% of staff respondents advised against disclosure
- ❖ 14% indicated they would advise students to disclose (in some circumstances)
- ❖ 5% indicated 'don't know'
- ❖ 72% of the sample indicated they felt there was an increase in the number of students disclosing mental illness in the past 12 months

Like students, staff also expressed strong views on disclosure and the quotations below are a representative sample of staff views on disclosure. Staff reasons for disclosure are grouped according to: support, safety, duty-of-care.

Table 17: Staff reasons for disclosure

Support	Safety	Duty-of-care
To receive support	to avoid crisis	to be prepared
Ensure special support	avert problems	to assist communication
To link into appropriate supports	safety reasons	so we are better able to help
More likely to receive special consideration	alert to warning signs	help teachers be more flexible in teaching
Access to support services	prevents barriers if proactive with strategies	helps planning for appropriate support
To access professional help	for intervention in crises	
Speeds process of getting extra help		

Staff reasons against disclosure were very similar to student concerns about stigma and acceptance.

Table 18: Staff reasons against disclosure

Stigma	Insufficient benefit	Lack of understanding
Disclosure probably detrimental in current environment	it's probably not worth it	poor acceptance by teaching staff
will lead to stigma; there's too much ignorance and prejudice		poor knowledge of confidentiality
fear of discrimination from some who would advise students to leave course		some educators are quite biased

Staff also reiterated the importance of disclosure as an individual decision ('is an individual decision'; 'student's choice'; 'is a personal issue').

Several staff indicated that the nature of improvements which would benefit students with mental health impairments (in terms of improved flexibility and individual understanding) would benefit *all* students.

A number of staff noted the value of partial disclosure and disclosure only in particular circumstances, citing circumstances such as:

- ❖ only if it affects learning
- ❖ only if legally appropriate
- ❖ depends on individual
- ❖ depends on department
- ❖ depends on student's level of acceptance of illness
- ❖ depends on teachers, many not very sympathetic
- ❖ only to counsellor or DLO
- ❖ depends on culture of the organisation
- ❖ only if something to be gained
- ❖ only if the problem has the potential for hurting self or others

Impact of psychiatric disability on study

The survey results, literature and qualitative interviews suggest that the functional impairments of mental disorders on study are principally in:

- ❖ cognitive functioning and concentration which impact on learning and judgement
- ❖ psychological functioning which impacts on confidence, motivation, consistency, goal perseverance and ability to self-correct one's experience
- ❖ emotional functioning and behaviour which impact on task completion and relations with others
- ❖ communication and social adaptation which impact on ability to explain needs, quality of staff and student relations, and group tasks

Because of the wide range of impairments and the unique nature of each individual student, a number of learning and support strategies and accommodations have been identified. These include curriculum modification, alternate assessment, academic and support staff availability, co-ordination by one worker (case management), study skills assistance and cognitive rehabilitation, psychosocial interventions, retreat areas, notetakers and tutors, and peer support.

Implications for personnel in the education setting

The project indicated a number of implications for staff in the post-secondary education setting. Based on focus group findings, interview notes and survey data, here are the current strengths, weaknesses and opportunities for improvement for support staff, teaching staff and management.

Role of disability liaison officer

Current strengths

- ❖ extensive knowledge of disability discrimination law and rights
- ❖ interviewing expertise and knowledge of educational context
- ❖ ability to provide functional assessment and planning of support measures
- ❖ skills in organisation and co-ordination of accommodations
- ❖ skills in negotiation and advocacy
- ❖ flexibility and timely responsiveness
- ❖ ability to facilitate liaison with academic staff
- ❖ brokering of tutoring, notetaking and other services
- ❖ pragmatic, problem-solving approach
- ❖ policy development

Possible weaknesses

- ❖ places students in disability context, (psychiatric terminology not popular with students)
- ❖ variable knowledge of mental disorders, impairments and appropriate accommodations
- ❖ large client loads
- ❖ insufficient time for intensive case management
- ❖ difficult to service across multi-campus facilities
- ❖ student disclosure may lead to stigma

Opportunities for improvement

- ❖ improved functional assessment of students with mental health issues through utilisation of outside psychiatric services
- ❖ assertive follow up and tracking of self-identified students
- ❖ identifying training and support needs of staff, e.g. teachers, tutors, notetakers
- ❖ anti-stigma campaigns
- ❖ introduction of crisis and safety measures
- ❖ anticipation of dysfunctional events
- ❖ skills training in responding appropriately to challenging events
- ❖ improved liaison with counsellors
- ❖ skill development in mental health issues
- ❖ involvement of other professionals in case conference and direct services
- ❖ need for psychological debriefing after incidents
- ❖ training students in self-advocacy, in conjunction with the student association
- ❖ inclusion of mental health impairment in all disability literature and presentations
- ❖ funding for case management

Current dilemmas

- 1 Dependence versus independence of student, for example, dependent student requires costly services.
Possible solution: encourage, but do not demand greater independence.
- 2 Accommodation versus discipline issues.
Possible solution: define acceptable behaviour if necessary and provide some accommodations and strategies to help student meet standard; educate staff about non-punitive consequences—except for harming others.
- 3 Financial decisions about budget containment.
Possible solution: defer unjustifiable hardship decisions to management; seek extra funding from disability support funds, other internal funds, or external mental health services or organisations.
- 4 Disability support versus case management expectations.
Possible solution: delegate case management to specialist worker for intensive ongoing support and co-ordination.
- 5 Disclosure versus non-disclosure of mental health issues.
Possible solutions: non-disability measures, for example, special consideration, group advocacy, referral to counsellor.
- 6 Notetaker ethics versus students' needs while ill.
Possible solutions: renegotiate notetakers' ethics to allow notetaking in absence of students; use trained volunteer notetakers.

- 7 Institutional rules and procedures are rigid and audited.
Possible solution: build in variation clause for disability circumstances.
- 8 Requesting formal diagnosis of mental disorder versus student's inability/unwillingness to obtain one.
Possible solutions: accepting internal counsellors' assessment or other indicator, such as receipt of the Disability Support Pension, previous psycho-educational difficulties/history, at-risk state (e.g. car accident may predispose to post-traumatic stress disorder).

Role of campus-based medical services

A health service is provided in universities but not usually in TAFE/VET-only institutions. The health service may employ general practitioners, psychiatrists or nurses, on a full-time or sessional basis. Not all students with mental health issues will access the health service, although a significant number appear to do so. The health service may prescribe or review medication, liaise with academic departments re student absence, refer to psychiatrists, or other mental health services, provide some counselling or hypnosis, consult to management and staff re student management. It is advantageous if at least one medical officer experienced in mental health is available on campus for timely access by students with mental health issues, even on a sessional basis.

Opportunities for improvement include providing a sessional psychiatry service on campus, and including a consultation liaison psychiatry service to staff and management.

The role of counsellors

Current strengths

- ♦ generalist role (e.g. personal, educational, vocational and possibly financial counselling) in most TAFE/VET-only settings; perceived as flexible and responsive. In universities, these roles are taken by specialist staff
- ♦ potential for case management (co-ordination of services, referral and follow up)
- ♦ non-medical model of mental disorders (students may reject the medical model)
- ♦ advanced empathy and relationship-building skills
- ♦ liaison and negotiation with external service providers
- ♦ can facilitate students' applications for special consideration and bypass disclosure of mental health impairment
- ♦ accessibility and proximity on campus (compared to external providers)
- ♦ understanding of mental health issues

Possible weaknesses

- ♦ incomplete knowledge of disability rights and possible accommodations/adjustments
- ♦ limitations in accessing the service (short-term counselling policies and waiting lists)
- ♦ unaware that policies of counselling service are also subject to unjustifiable hardship provision (e.g. short-term counselling limits may be too harsh on students with mental health issues and may need to be waived or extended until unjustifiable hardship can be demonstrated)

- ❖ variable knowledge of mental health issues, mental health services, and ways of working with people with mental health issues
- ❖ ethical limitations re area of competence
- ❖ lack of resourcing of independent clinical supervision (time and cost)

Opportunities for improvement

- ❖ Improve assessment practices including differential and provisional diagnosis of mental disorders.
- ❖ Improve liaison with disability officers, clarification of roles and overlap, and parameters for cross-referral.
- ❖ Employ or train at least one specialist staff member in mental health issues (including clinical psychologists or neuropsychologists, psychiatric nurses, psychiatrist).
- ❖ Differentiate or extend counsellor roles.

Examples include: primary treatment, adjunct treatment, supportive therapy, secondary consultation, psychosocial and educational rehabilitation, functional and diagnostic assessment, psychiatric disability support, educational 'maintenance' of students, monitoring and problem-solving, stress management, disability-related counselling, prevention of crisis or relapse, crisis intervention, psychological debriefing, personal growth/enrichment, psycho-education, skills training, case management, staff training, self-esteem building, student peer support training or facilitation, cognitive rehabilitation, behaviour or self-management training for students.

- ❖ Develop referral protocols and detailed referral information on service providers (including cost and availability) and treatment outcomes (e.g. evaluate effectiveness of the referral process and external services).
- ❖ Extend length and quality of vocational and educational counselling services for prospective students with mental health issues.
- ❖ The most promising therapeutic non-medical models appear to be the cognitive therapy model (Beck 1994), the self-psychology model, the schema-focussed cognitive therapy (Young 1994; Guidano, 1991; Lee & Martin 1991), the intersubjective perspective (Stolorow, Atwood & Brandchaft 1994) and holistic recovery models (Watkins 1994).
- ❖ If the student has cognitive/neuroregulatory/executive deficits, then assistance in the areas of self-regulation, attention, focus and organisation needs to be provided through cognitive rehabilitation and learning skills by educational counsellors and individual tutors (Palombo 1996).

Dilemmas

- ❖ Some students not wanting 'treatment' versus students wanting 'support' or a 'friend'. Some students feel 'counselled out' but still want someone to understand and support them.
Possible solution: rename program, e.g. study and wellness program, support and co-ordination, or stress management.
- ❖ Students rejecting psychiatric diagnosis, external mental health services, or medication as stigmatising versus limited resources of campus counselling services.
Possible solutions: find non-stigmatising alternatives, increase counselling staff, consult with mental health services for advice/supervision, obtain external funding for extended services.
- ❖ Areas of competence not clinical psychology versus pressure to assist students with mental health issues.

Possible solutions: extend area of competence through funded training and industry work placement, define boundaries of service, obtain clinical supervision, emphasis on educational, rehabilitation and disability support frameworks, primary treatment for some but not all disorders: e.g. include adjustment and some anxiety disorders but not bi-polar, schizophrenia, obsessive compulsive disorder (OCD).

- ❖ Confidentiality versus duty-of-care.
Possible solutions: define duty-of-care situations, train in risk assessment, explain confidentiality limitations to student, obtain permission to act before a crisis, consult with student's treatment provider, obtain student's permission to inform relevant others, define referral process and follow up, define internal accountability process, design quality procedures and recording mechanisms.
- ❖ Student's preference for one support person versus specialist student services.
Possible solutions: take over other specialist functions but increase contact time: accompany student to other specialist services to model a request or negotiation, advocate for student, facilitate use of other services by an introduction letter, call in other providers to come to your office.

The role of the learning skills advisor or educational counsellor

In TAFE/VET, this function is often split between counsellors, language support assistance and the academic department. At university, a specialist service is usually provided.

Opportunities for improvement

- ❖ improved availability of functional assessment of learning skills, learning style, psycho-educational functioning
- ❖ greater emphasis on specialist learning skills assistance and group programs (in TAFE/VET)
- ❖ enhancement of cognitive rehabilitation/learning difficulties/educational psychology expertise
- ❖ introduction of computer-assisted cognitive rehabilitation exercises
- ❖ return-to-study programs, bridging courses or short courses developing organisational and communication skills
- ❖ facilitation of peer support pairs, study groups/circles
- ❖ improve liaison with disability staff regarding course and testing accommodations
- ❖ affirm student's academic efforts and achievements

Dilemmas

- ❖ Maximum assistance versus academic integrity.
Possible solutions: negotiate a transition period in which maximum assistance teaches the requisite skills and then is gradually withdrawn to 'reasonable' level of assistance; clarify unjustifiable hardship in relation to academic integrity; elicit and document student's contribution through alternative means, e.g. verbally, in diagrams, in notes, in drafts, in plans.
- ❖ Diagnosing weaknesses and teaching learning strategies versus destroying student's confidence.
Possible solutions: always affirm student's strengths, suggest areas for improvement; ask what they would like to learn; check frequently if student is co-operative, understands the new skill and/or finds it useful.

- ♦ Professional as expert in their field versus student as expert on him/herself. Possible solutions: elicit and comprehend student's view of their learning style/skills; respect and recognise alternative explanations; start from their expressed need; work in new strategies through their framework/language, otherwise may upset the student's equilibrium.

The role of the academic department

Strengths

- ♦ provision of structured learning experience which is available in TAFE/VET
- ♦ many teachers are accommodating if mental health issues disclosed and some strategies suggested
- ♦ many teachers show empathy, interest in student's progress
- ♦ staff who have familial experience of mental health issues themselves may be more aware

Difficulties

- ♦ high turnover of staff makes continuity difficult
- ♦ sessional staff have little time for meetings or one-to-one support
- ♦ lack of information or training on how to deal with students with mental health issues
- ♦ difficult to act appropriately if mental health issues not disclosed by student
- ♦ full-time staff may have insufficient time allotment for one-to-one assistance outside class
- ♦ some stigma, prejudice
- ♦ working with paranoid students or students with personality disorders
- ♦ unclear about confidentiality

Opportunities for improvement

- ♦ develop confidentiality parameters
- ♦ obtain further training on mental health issues and empathy
- ♦ obtain regular psychological debriefing when working with students with mental impairments
- ♦ separate mental health issues from behavioural issues (not always possible)
- ♦ continue to provide or integrate course, testing and other accommodations/adjustments
- ♦ continue to give or extend individual attention to students with mental health issues in class, not first and not last
- ♦ handle grievances sensitively, recognise and repair department's errors, obtain outside opinion and/or mediation, strike a compromise or balance between accommodations and consequences or expectations
- ♦ allow for gaps in attendance due to stress/illness
- ♦ don't predict student's suitability to meet the inherent requirements for the career or employers' ability to accommodate the person with mental health issues
- ♦ selection tests/criteria may need to be adjusted as in alternate assessment

The role of notetakers, tutors, and participation assistants

Current strengths

- ❖ monitor and assist the student academically
- ❖ provide company and support as a mature companion
- ❖ motivate and encourage student
- ❖ assist student with organisation, planning, tracking, academic tasks
- ❖ show concern for the student's well-being and academic progress
- ❖ are in a position to identify student's gaps and needs

Possible difficulties

- ❖ notetakers' ethics prevent notetaking while student is absent
- ❖ variable understanding of mental health issues
- ❖ lack detailed information on student's functional deficits and how to address them
- ❖ not usually authorised to intervene with student's psychosocial and emotional issues but have to witness them, causing discomfort
- ❖ not usually trained in crisis intervention and safety
- ❖ not always trained in learning skills

Opportunities for improvement

- ❖ combine and expand participation assistant role to include tutoring, notetaking and dealing with psychosocial and emotional issues in the classroom
- ❖ obtain clinical consultation, supervision and clarification from counsellor, disability liaison officer or other specialist/case worker
- ❖ preference for psychiatric disability support qualifications or experience
- ❖ train in empathy and support principles and crisis intervention
- ❖ report student's progress, needs, incidents, triggers, to student's case worker
- ❖ written clarification of extent of academic assistance without doing the work for the student
- ❖ collaborate with learning skills advisor on addressing learning needs

Role of managers

Findings from the survey, focus group discussions and interviews with education staff and mental health professionals indicate the following recommendations for best practice.

Recommendations for best practice

- 1 Ensure the implementation of policies such as diversity, occupational health and safety, and confidentiality that are inclusive of mental health issues of students.
- 2 Obtain legal briefing/advice on duty-of-care for the various professionals in the department and for the manager.
- 3 Continue to clarify responsibilities conferred by the Disability Discrimination Act, and consider what would constitute unjustifiable hardship, in the context of mental health issues and the size of the educational institution.
- 4 Enhance the resourcing of clinical consultation for staff dealing with students with mental health issues (acknowledging need for additional time).

- 5 Allot appropriate time for staff training, meetings, debriefing and clinical consultation regarding mental health issues.
- 6 Liaise with appropriate staff on strategies for minimising stress and preventing incidents.
- 7 Address issues of unacceptable behaviour in the context of appropriate accommodations; minimise disciplinary action if behaviour occurred during a psychotic episode; consider on a case-by-case basis in conjunction with legal advice.
8. Advance flexibility with course and academic rules, up to the point of unjustifiable hardship.
- 9 Recognise the student's diagnostic documentation for specified period, e.g. 1–4 years or longer depending on the disorder.
- 10 Admissions and course procedures to have a variation clause for disabled students.
- 11 Allow retrospective adjustments if student was unable to communicate needs or disclose mental health issues earlier.
- 12 Recognise that imputing a psychiatric disability or a likelihood of future psychiatric disability confers DDA responsibilities.
- 13 Arrange external mediation where there is conflict or major misunderstanding.
- 14 Build collaborative linkages with mental health services.
- 15 Manage critical incidents and train staff in critical incident prevention, risk assessment, intervention and postvention.
- 16 Practise risk management, (e.g. costs of possible litigation can be prevented by appropriate practices and resourcing of staff; learn from other litigation cases).
- 17 Involve consumer consultants (e.g. students with mental health issues) in decision-making on evaluation and improvement of services.

Supported education programs

Supported education programs or specialist bridging programs, developed by educational institutions with advice and support from the mental health sector, would enable prospective students to develop the skills necessary for success in the post-secondary sector.

Integrated support structures that incorporate high quality best practice management in key processes and implementations will provide the most effective support.

A comprehensive supported education program for students with mental health issues should have the following specialised components:

- 1 specialised bridging study skills and orientation programs
- 2 outreach to prospective students and assistance with applications
- 3 specialised vocational and course counselling
- 4 individual education plan
- 5 case manager/co-ordinator for students with high support needs
- 6 disability service (including identification and arrangement of accommodations in all services and facilities, policy development, curriculum modification, organisation of direct learning assistance—notetakers, participation assistants and tutors—advocacy, consultation to staff, technical aids)

- 7 counselling service (psychological, psycho-educational and psychosocial interventions and support, consultations to staff)
- 8 learning skills assistance (study skills, cognitive rehabilitation)
- 9 academic reference group on strategies
- 10 financial assistance (maximal concessions and loans, extended service, advocacy and referral)
- 11 housing assistance (extended service, specialist referral to supported housing)
- 12 crisis management for crises related to mental health issues (including legal advice on duty-of-care and confidentiality)
- 13 peer support and self-advocacy (partly through the student association)
- 14 awareness training for general staff and students
- 15 professional development for program staff
- 16 research and evaluation
- 17 paid consultation with consumers
- 18 collaboration with external mental health organisations and services
- 19 expansion of services to flexible delivery, internet and distance education students
- 20 fieldwork and employment search support

Implications for staff training

Focus group discussions with staff had indicated that they felt relatively comfortable when dealing with students' minor problems. However, there was a very clear indication that in cases of extreme student behaviour or incidents of serious mental anguish, staff have felt totally powerless to intervene effectively and felt in great need for some form of resource or referral system. These situations were often associated with highly disturbing behaviour in lectures including violence or the perception of impending violence. A teaching staff member gave the example of a case where a student became extremely unpredictable and had thrown chairs across the room. The student had apparently developed a medical condition during his course and was receiving medical treatment to help overcome it. In this case the academic feared for her own safety and that of the class. She also expressed fear for the children that this teaching student might have exposure to at some later point in time.

It was precisely this kind of concern that prompted many staff members to participate in the focus groups, hoping they might gain additional knowledge or contribute in some way to the development of a resource.

The need for staff to be able to access assistance in cases of student difficulty or extreme behaviour was felt acutely. One of the key issues was the availability of instant contact. One participant related a story about how they had a student in their office while they frantically made a series of telephone calls trying to find assistance for them. Focus group participants expressed the need for a directory where mental health issues could be described and further information could be gained that might include immediate actions to deal with difficulties and a list of contact numbers.

Both teaching and support staff were acutely aware that the phrase 'a little knowledge is a dangerous thing' might be true in the case of intervening with troubled students. It was felt that in-depth training in the area of crisis

intervention was probably unrealistic. A more realistic solution was training aimed at creating an awareness of where resources and specialists were located and how they might be accessed.

It was clear from each group that the issue of psychiatric disability among students was both serious and pressing for academic and support staff. A number of the groups expressed how pleased they were to see an initiative in this area in action. It was also clear from each group that the language used to discuss or describe mental wellness and illness was limited at best and, at worst, was capable of clouding the issues. Participants frequently requested clarification of definitions and were concerned about exactly what the group was permitted to focus on.

Survey responses and focus group discussion suggest that training for staff who work with students with psychiatric disability should include:

- ✦ guidance in understanding behaviours of concern
- ✦ information about the possible side-effects of medication
- ✦ knowledge of disability legislation and student rights
- ✦ mental health awareness issues
- ✦ knowledge of alternative assessment options
- ✦ training in empathy skills
- ✦ implications for field work
- ✦ information on learning issues and support
- ✦ guidance in determining the boundaries of appropriate relations and responsibility
- ✦ guidance in handling particular situations or behaviour
- ✦ confidentiality guidelines
- ✦ non-discriminatory selection guidelines
- ✦ advocacy and negotiation options

External issues

Many of the issues which impact on the success and progression rates of students with mental impairments are extramural.

Possible strategies to reduce the impact of these include:

- ✦ changes in Austudy requirements, from 25 per cent of a course workload for students with psychiatric disability to four hours of contact time per week
- ✦ funding to be available from government mental health services to cater for psychiatric disability support and rehabilitation of students with mental health impairments in the post-secondary education setting
- ✦ clinical training, industry placement, and clinical supervision to be provided by public mental health services to counsellors and disability liaison officers
- ✦ establishment of a central resource centre on mental health impairments in post-secondary education be set up and funded by DEETYA and State departments of education
- ✦ educational disability support funds to fund individual student case management/stress management or support and fieldwork support in its funding guidelines

- ❖ Austudy to change its requirements to accept evidence of mental disorder from a psychiatrist only to include psychologists as well, in cases of less 'serious' mental disorders (other than mood, psychoses, obsessive compulsive disorder and panic disorders)
- ❖ low-cost clinical psychology/social work professional development units to be available for non-clinically trained staff of counselling centres by professional associations, and universities
- ❖ extended financial assistance, loans and grants to be available for students with mental health impairments

Certainly for the young people involved, there were many advantages to being a student rather than a patient. For educational institutions, the desirability of maximising opportunities for sustaining progression and success rates for all students, including those with special needs, is an economic as well as educational goal.

Conclusions

The issue of psychiatric disability in the higher education context is extremely complex. The heterogeneous nature of psychiatric disability means that its impact on learning varies considerably. This heterogeneity must, in turn, be seen against a background of individual difference in learning and thinking styles and inter- and intra-institutional differences in response to disability. The issue of stigma is also a major factor; post-secondary institutions are in many ways a microcosm of society, reflecting society's myths and misconceptions about mental illness.

Perhaps more than in other disability areas, support for students with psychiatric disability crosses a number of professional boundaries. Disability support staff, counsellors, health professionals and mental health specialists all expressed strong feelings about where they felt responsibility for the support of students with psychiatric disability would lie. The very nature of the disability itself also compounds the issue, in that the paranoia and impaired judgement which may be part of the illness may affect students' perceptions of the support they receive.

There are clear limitations in the way data has been collected in this study. Student and staff groups (whether to participate in focus group discussion or to complete a survey) were accessed through the disability office on each campus. The sample is therefore, of necessity, biased; student participants will generally have disclosed their disability (and are therefore comfortable enough with their condition to respond to questioning). Staff participants will have particular interest in the area of mental health either because of negative or positive experiences. In all cases they are unlikely to be representative of the general student/staff population. The findings, therefore, relate to the views of only one section of the target group. The complexity and heterogeneity of the group 'students with psychiatric disability' is acknowledged, but may not have been fully represented by the project sample. In many ways this reflects an underlying problem of providing support to the target group; support is contingent on disclosure of disability and, in this sense, a sample which reflects the views of students who have disclosed must be accepted.

The policies relevant to post-secondary education and mental health impairments clearly indicated that students with mental health impairments are a part of diversity of the student population, cannot be discriminated against and need to be supported appropriately. The diverse nature of psychiatric disability or mental health impairment points to a complex set of needs and a challenge to educational institutions. A sophisticated set of learning, support and systemic strategies is required to maximise the participation and completion rates of students with mental health impairments. Both internal (educational) and external services and support systems need to be adjusted to meet the requirements of this group for academic and vocational success.

The issue of support for students with psychiatric disability is an important one. One in five adults will suffer a mental illness at some time in their lives (National Mental Health Policy 1992; Mental Health Strategy Plan 1994) and most contract

it just at the age they are entering post-secondary education and training. Returning to work and study is acknowledged as crucial to successful rehabilitation, yet the thinking and learning processes essential to educational success are profoundly affected by mental illness. On a macro level, the successful implementation of any support for students with psychiatric disabilities will depend on the involvement and commitment of all interest groups, including mental health services, agencies and advocacy groups. Employer groups, as well as academic and support staff and the general student population, need to be educated about the myths and realities of mental illnesses. Lack of understanding of mental illness (generally, as well as its impact on learning) is inhibiting participation of a significant number of students. In addition to legislative and policy developments, there is a need to develop understanding and attitudinal change if Australia is to benefit economically and socially from the potential contribution of this group of students.

The resource kits which accompany this report:

Mental health issues on campus: Resource kit for staff

Mental health issues on campus: Resource kit for students

are intended to meet some of the needs highlighted by the report's findings.

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Appendix 1: Interviews and focus groups

The project team would like to thank the many students, staff and mental health professionals who gave unstintingly of their time and willingly shared their expertise.

Interviews

The following people were interviewed.

Disability liaison officers

Lloyd Bennetts, DETAFE disability co-ordinator, SA
Gillian Bruce, Monash University
Debra Clarke, DETAFE regional DLO, SA
Amber Colling, Box Hill TAFE
Martin Fathers, RMIT TAFE and University
Louise Finley, manager, disability, TAFE NSW
Lisa Kavanagh, Box Hill TAFE
Carmel Lincoln, Kangan Batman Institute of TAFE
Jenny Madden, South West Institute of TAFE
Angie Muccillo, Northern Metropolitan Institute of TAFE
Lorri Parnell, Kangan Batman Institute of TAFE
Leslie Porter, Riverina TAFE
Julia Powell
Annette Rudd, Monash University
Janette Ryan, Australian Catholic University
Jenny Shaw, RDLU
Marilyn Shaw, University of South Australia
Peta Smith, Sydney Institute of TAFE
Ian Shore, Torrens Valley TAFE
Kathryn Stuckings, University of Sydney
Jacqui Tomlins, LaTrobe University
Sandra van Rompey, Bendigo Institute of TAFE
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Ann Garden, Peninsula TAFE and Monash University
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Louise King, South West TAFE
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Judith Mills, Ballarat TAFE
Malcolm Morgan, Richmond Fellowship of Victoria
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Dick Sladden, University of South Australia
Chris Tanti, University of Melbourne

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Kate Channock, La Trobe University
Tanya Clarke, University of Melbourne
Eric Fuss, Torrens Valley TAFE
Elizabeth Powell, Australian Catholic University (Christ)

Mental health organisations

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Elizabeth Crowther, director, Victoria Schizophrenia Fellowship
Nick Gaynor, CATS manager, North West Area Mental Health Service
Jill Gray, VICSERV
Maureen Judd, Agoraphobia Support Group
Professor Patrick McGorry, director, Centre for Young People's Mental Health
Lyn McKenzie, Mental Health Branch, Department of Human Services Victoria
Paul Morgan, SANE Australia
Michael O'Brien, VMIAC
Arthur Papakotsias, president, VICSERV
Liz Schulz, North West Adelaide Mental Health Services
Irene Towler, Schizophrenia Fellowship SA
Anne Marie Wright, EPPIC

Employment and rehabilitation agencies

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Catherine Carr, Disability Employment Action Centre
Leonie Exel, North Eastern Placement Service
Louise Firminger, Heidelberg Skillshare
Andrea Gutch, Worklink
Bronwyn Jellie, CRS Cheltenham
Andrew McKenzie, manager, Community Mental Health Program,
Western Health Care Network
Gabby Ramsey, CRS Cheltenham
Helen Salvati, CRS Footscray
Mark Silver, CRS Cheltenham
Chris Thompson, CRS Footscray

Students/consumers

Ria Strong, OzAdvocacy
Margaret Woollard, Outer Eastern Institute of TAFE
Arna Delle Vergini, MASC University of Melbourne

Students from:

Kangan Batman Institute of TAFE
School of Mines Ballarat
Bromham Place, Richmond
Northern Metropolitan Institute of TAFE
Box Hill Institute of TAFE
Outer Eastern Institute of TAFE
University of Melbourne
Adelaide Institute of TAFE
Monash University
Australian Catholic University
Council of Adult Education

Other professionals

Esther Aarons, senior head teacher, Sydney Institute of Technology
Dr Margaret Bullen, director, Health Service, University of Melbourne
Prue Capell, course co-ordinator, Ballarat School of Mines
Marie Hapke, access recreation officer, Port Melbourne Council
Melinda Freyer, co-ordinator, Centre of Work Education,
Kangan Batman Institute of TAFE

Sue Jellett, manager, Student and Information Services, Kangan Batman Institute of TAFE
Wayne Jencke, Kangan Batman Institute of TAFE
Lawrence Kerr, Preston/Reservoir Neighbourhood House
Dr Paul Leung, School of Studies in Disability, Deakin University
George McLean, Director of Research, OTFE
Dr Johanna Wyn, Youth Research Centre, University of Melbourne

Focus groups

Focus groups were held in Victoria, New South Wales, Queensland and South Australia with staff from both metropolitan and regional campuses with group membership varying from six to 15.

A total of 14 focus groups were held:

TAFE DLO Network (2)
TAFE teachers (metropolitan)
TAFE teachers (rural)
Bromham Place (prospective students)
TAFE students—rural
TAFE counsellors
University counsellors
TAFE/university learning skills advisors
University teachers (rural—2)
University teachers (metropolitan—2)
University students (metropolitan)

Appendix 2: Surveys

Prospective student survey

Student survey

Staff survey

Mental Health Issues in Post-Secondary Education Survey

for people considering further study

Thank you for taking the time to complete this survey. We are very interested to hear your views about studying at university or TAFE. Your answers are completely confidential and it will not be possible to identify individual responses. The results will be analysed and the information provided to universities, TAFE institutions and private training colleges to help them improve the services available to students.

Jana Andrews and Patricia McLean

Please return the completed survey to:

PsychDis Project
Equity and Learning Programs Unit
University of Melbourne
Parkville, 3052
VICTORIA

We would appreciate it if the survey could be returned by November 15

If you have any questions or concerns, please contact:
Jana Andrews or Patricia McLean on 03 9344 8030/0029
or email: p.mclean@elp.unimelb.edu.au

This survey is part of the *PsychDis* Project, an NCVER funded project investigating the support needs of students with mental health issues who are studying (or would like to study) in post secondary education.

MENTAL HEALTH ISSUES IN POST-SECONDARY EDUCATION SURVEY

PART A Please tell us a bit about yourself

1. Are you female? ☐ male? ☐
2. What age group are you in?

17 and under ☐	18-21 ☐	22-30 ☐
31-40 ☐	41-50 ☐	51+ ☐
3. What was your highest level of educational level

Pre VCE (year 10 and below)	☐
VCE (incomplete)	☐
VCE (completed successfully)	☐
VCE equivalent	☐
TAFE course _____	☐
University course _____	☐
4. What was your reason for discontinuing your education?

5. Where would you prefer to study? TAFE ☐ University ☐
 Private training college ☐ Other: _____
6. What course/s are you thinking of applying (or re enrolling in)? (Please indicate course title and level, eg Certificate IV of Art and Design; first year Bachelor of Science)

7. Would you study full-time? ☐ part-time? ☐ as an off campus student? ☐

PART B Please tell us a bit about your mental health issue

8. If you were diagnosed with a mental health condition, what was the diagnosis? (You may tick more than one). Please indicate past conditions as well.

- | | | | |
|---------------------------------|--------------------------|--------------------------------|--------------------------|
| Major depression | ☐ | Panic disorder | ☐ |
| Bipolar disorder | ☐ | Phobia | ☐ |
| | | Obsessive compulsive | ☐ |
| | | Acute stress reaction | ☐ |
| | | Post traumatic stress disorder | ☐ |
| | | Adjustment disorder | ☐ |
| Psychosis | ☐ | Learning disorder | ☐ |
| Schizophrenia | ☐ | Asperger's disorder | ☐ |
| Schizoaffective disorder | ☐ | ADD/ADHD | ☐ |
| | | Conduct disorder | ☐ |
| Anorexia Nervosa or Bulimia | ☐ | | |
| Borderline personality disorder | ☐ | | |
| Alcohol or drug dependence | ☐ | | |

Other: _____

9. Who diagnosed your condition?

- | | | | | | |
|------|--------------------------|--------------|--------------------------|--------------|--------------------------|
| GP | ☐ | Psychologist | ☐ | Psychiatrist | ☐ |
| self | ☐ | other: | _____ | | |

10. How long ago were you first diagnosed?

- | | | | |
|------------------|--------------------------|--------------------|--------------------------|
| Less than a year | ☐ | 1-5 years | ☐ |
| 6-10 years | ☐ | More than 10 years | ☐ |

11. Have you taken any medication for the condition this week?

- | | | | |
|-----|--------------------------|----|--------------------------|
| Yes | ☐ | No | ☐ |
|-----|--------------------------|----|--------------------------|

12. Are you seeing a psychiatrist at the moment?

- | | | | | |
|----|--------------------------|-----|--------------------------|------------------|
| No | ☐ | Yes | ☐ | How often? _____ |
|----|--------------------------|-----|--------------------------|------------------|

11. Which of the following aspects of studying at university/TAFE do you think would be affected by your mental health condition. You may indicate more than one.

concentration in classes	☐	concentration when studying	☐
motivation	☐	problem solving	☐
reading skills	☐	writing skills	☐
keeping to deadlines	☐	adapting to college social life	☐
remembering	☐	getting organised	☐
regular class attendance	☐	relating to people	☐
communicating	☐	explaining your needs	☐
sitting for exams	☐	feeling at home on campus	☐
confidence	☐	other: _____	

12. Would you disclose your mental health condition to someone at Uni or TAFE?

Yes ☐ No ☐

Why? _____

PART C What do you think about studying?

13. I would get satisfaction from studying.

1 2 3 4 5
strongly agree agree undecided disagree strongly disagree

14. I would like being a student.

1 2 3 4 5
strongly agree agree undecided disagree strongly disagree

15. After a while, I lose sight of my goals.

1 2 3 4 5
strongly agree agree undecided disagree strongly disagree

16. I lack the drive to get my work done.

1 2 3 4 5
strongly agree agree undecided disagree strongly disagree

17. I find it hard to get going on anything important.

1 2 3 4 5
strongly agree agree undecided disagree strongly disagree

18. I have a clear sense of where my life is going.

1 2 3 4 5
strongly agree agree undecided disagree strongly disagree

19. What were your last academic results?

Fail ☐ Pass ☐ Credit ☐ Honours ☐

20. I was happy with my last academic results.

1 2 3 4 5
strongly agree agree undecided disagree strongly disagree

21. Which of the following off campus people do you think would support you in your studies? (You may tick more than one)

- | | | | | | |
|--------------|--------------------------|------------------|--------------------------|-----------------|--------------------------|
| mother | ☐ | fellow students | ☐ | close friend(s) | ☐ |
| father | ☐ | brothers/sisters | ☐ | partner | ☐ |
| case manager | ☐ | doctor | ☐ | psychologist | ☐ |

other _____

22. Would you like to attend a 'preparation for study' bridging course if it were available?

Yes ☐ No ☐

Why? _____

23. The ideal length of such a bridging course would be.

1-5 days ☐ 1-4 weeks ☐ 5-10 weeks ☐

1 semester ☐ 1 year ☐ other _____

24. What would you like the bridging course content to include? (You may tick more than one)

- | | | | |
|--------------------------------|--------------------------|--------------------------|--------------------------|
| motivation and goal planning | ☐ | confidence building | ☐ |
| orientation to university/TAFE | ☐ | stress management skills | ☐ |
| flexible delivery | ☐ | time management | ☐ |
| stress management skills | ☐ | organisational skills | ☐ |
| reading skills | ☐ | note taking skills | ☐ |
| oral presentation skills | ☐ | essay writing skills | ☐ |
| exam skills | ☐ | computing skills | ☐ |
| assertiveness training | ☐ | people relating skills | ☐ |

other: _____

If you have not studied at university or TAFE before, go to Part E.

PART D If you studied at university or TAFE previously, what do you think of the help you received?

25. How well did the following people understand your needs and how useful was their assistance? Using the table below, rate their help on a scale from 1-5, by circling the appropriate number. Please give an example of the type of assistance you received.

1 2 3 4 5
strongly agree agree undecided disagree strongly disagree

On campus help	Understood my needs	Assisted me	Examples of the assistance I received
Course co-ordinator	1 2 3 4 5	1 2 3 4 5	
Lecturers/teachers	1 2 3 4 5	1 2 3 4 5	
Disability Liaison Officer	1 2 3 4 5	1 2 3 4 5	
Counsellor	1 2 3 4 5	1 2 3 4 5	
Study skills adviser	1 2 3 4 5	1 2 3 4 5	
Student Association	1 2 3 4 5	1 2 3 4 5	
Administrative staff	1 2 3 4 5	1 2 3 4 5	
fellow students	1 2 3 4 5	1 2 3 4 5	
campus doctor	1 2 3 4 5	1 2 3 4 5	
Faculty Special needs co-ordinator	1 2 3 4 5	1 2 3 4 5	
special needs tutor	1 2 3 4 5	1 2 3 4 5	
other (who?)	1 2 3 4 5	1 2 3 4 5	

PART E What can universities/TAFEs do to help?

Here are a number of suggestions people have made about useful supports for studying at University or TAFE. In your view, how useful would they be to you if they were available?

26. I would like a quiet space where I can go if I feel stressed.

1	2	3	4	5
strongly agree	agree	undecided	disagree	strongly disagree

27. I would like to have someone I can talk to if/when I need it.

1	2	3	4	5
strongly agree	agree	undecided	disagree	strongly disagree

28. I would like more flexibility in course completion times.

1	2	3	4	5
strongly agree	agree	undecided	disagree	strongly disagree

29. I would like more flexibility in assessment tasks, (eg extensions, alternative exam arrangements)

1	2	3	4	5
strongly agree	agree	undecided	disagree	strongly disagree

30. I would like study skills help.

1	2	3	4	5
strongly agree	agree	undecided	disagree	strongly disagree

31. I would like extra tutorial assistance for specific subjects.

1	2	3	4	5
strongly agree	agree	undecided	disagree	strongly disagree

32. I would like a peer mentor or 'study buddy'.

1	2	3	4	5
strongly agree	agree	undecided	disagree	strongly disagree

33. I would like more flexibility in my course timetable.

1	2	3	4	5
strongly agree	agree	undecided	disagree	strongly disagree

34. I would like more opportunity to give feedback to my university/TAFE as a consumer.

1	2	3	4	5
strongly agree	agree	undecided	disagree	strongly disagree

35. I think lecturers/teachers need more training on mental health issues.

1	2	3	4	5
strongly agree	agree	undecided	disagree	strongly disagree

36. What suggestions would you make to improve study at university/TAFE?

All responses are completely confidential.

Please indicate which state/territory you are studying in:

Victoria	☐	Qld	☐	SA	☐	NT	☐
NSW	☐	Tas	☐	ACT	☐	WA	☐

Thank you for taking the time to fill in this survey, we hope it will result in increased understanding and improved services for students studying at universities and TAFEs.

Patricia McLean and Jana Andrews

Please return the completed survey to:

PsychDis Project
Equity and Learning Programs Unit
University of Melbourne
Parkville, 3052
VICTORIA

We would appreciate it if the survey could be returned by November 15

If you have any questions or concerns, or would like further information, please contact:
Jana Andrews or Patricia McLean on 03 9344 8030/0029
or email: p.mclean@elp.unimelb.edu.au

BEST COPY AVAILABLE

Mental Health Issues in Post-secondary Education Student Survey

Thank you for taking the time to complete this survey. We are very interested to hear your views about studying at university or TAFE. Your answers are completely confidential and it will not be possible to identify individual responses. The results will be analysed and the information provided to universities, TAFE institutions and private training colleges to help them improve the services available to students.

Jana Andrews and Patricia McLean

Please return the completed survey to:

*PsychDis Project
Equity and Learning Programs Unit
University of Melbourne
Parkville, 3052
VICTORIA*

We would appreciate it if the survey could be returned by November 15

If you have any questions or concerns, please contact:
Jana Andrews or Patricia McLean on 03 9344 8030/0029
or email: p.mclean@elp.unimelb.edu.au

This survey is part of the *PsychDis* Project, an NCVET funded project investigating the support needs of students with mental health issues who are studying in post secondary education.

MENTAL HEALTH ISSUES IN POST-SECONDARY EDUCATION

All responses are completely confidential

PART A Please tell us a bit about yourself

1. Are you: female ☐ male ☐
2. What age group are you in?
 17 and under ☐ 18-21 ☐ 22-30 ☐
 31-40 ☐ 41-50 ☐ 51+ ☐
3. What language do you speak at home?
 English ☐ Other ☐ _____
4. Are you studying at TAFE? ☐ University? ☐ Other ☐
 What course are you studying? (Please indicate course title and level, eg Certificate IV of Information Technology; Bachelor of Arts.)

5. What year level are you in your course?
 First year ☐ year 1-5 ☐ postgraduate ☐
6. Are you full-time? ☐ part-time? ☐ an off campus student? ☐

PART B Please tell us a bit about your mental health issue

7. Which of the following aspects of studying are affected by your mental health condition? You may indicate more than one.

concentration in classes	☐	concentration when studying	☐
motivation	☐	problem solving	☐
reading skills	☐	writing skills	☐
keeping to deadlines	☐	adapting to college social life	☐
remembering	☐	getting organised	☐
regular class attendance	☐	relating to people	☐
communicating	☐	explaining your needs	☐
sitting for exams	☐	feeling at home on campus	☐
confidence	☐	other: _____	

8. Have you had to take time out this year because you were unwell?

Yes ☐ No ☐

9. If you were diagnosed with a mental health condition, what was the diagnosis? (You may tick more than one). Please indicate past conditions as well.

Major depression	☐	Panic disorder	☐
Bipolar disorder	☐	Phobia	☐
		Obsessive compulsive	☐
		Acute stress reaction	☐
		Post traumatic stress disorder	☐
		Adjustment disorder	☐
Psychosis	☐	Learning disorder	☐
Schizophrenia	☐	Asperger's disorder	☐
Schizoaffective disorder	☐	ADD/ADHD	☐
		Conduct disorder	☐
Anorexia or Bulimia Nervosa	☐		
Borderline personality disorder	☐		
Alcohol or drug dependence	☐		

Other: _____

10. Who diagnosed your condition?

GP ☐ Psychologist ☐ Psychiatrist ☐
self ☐ other: _____

11. How long ago were you first diagnosed?

Less than 1 year ☐ 1-5 years ☐
6-10 years ☐ More than 10 years ☐

12. Have you taken any medication for the condition this week?

Yes ☐ No ☐ (Go to question 14)

13. In your view, the side effects of medication have hindered your studies:

1 2 3 4 5
strongly agree agree undecided disagree strongly disagree

14. Are you seeing a psychiatrist at the moment?

No ☐ Yes ☐ How often? _____

15. Have you disclosed your mental health condition to someone in the University/TAFE?

Yes ☐ No ☐

16. Would you advise other students to disclose?

Yes ☐ No ☐

Why? _____

17. Did you apply for special consideration?

Yes ☐ No ☐ Didn't know about it ☐

18. Did you apply for special accommodations?

Yes ☐ No ☐ Didn't know about it ☐

19. Which of the following **off campus** people support you in your studies. (You may tick more than one)

mother ☐ fellow students ☐ close friend(s) ☐

father ☐ brothers/sisters ☐ partner ☐

case manager ☐ doctor ☐ psychologist ☐

other _____

PART C What do you think of the help you have received while at your university of TAFE

20. How well did the following people understand your needs and how useful was their assistance? Using the table below, rate their help on a scale from 1-5 by circling the appropriate number. Please give an example of the type of assistance you received as well.

1 2 3 4 5
strongly agree agree undecided disagree strongly disagree

On campus help	Understood my needs	Assisted me	Examples of the assistance I received
Course co-ordinator	1 2 3 4 5	1 2 3 4 5	
Lecturers/teachers	1 2 3 4 5	1 2 3 4 5	
Disability Liaison Officer	1 2 3 4 5	1 2 3 4 5	
Counsellor	1 2 3 4 5	1 2 3 4 5	
Study skills adviser	1 2 3 4 5	1 2 3 4 5	
Student Association	1 2 3 4 5	1 2 3 4 5	
Administrative staff	1 2 3 4 5	1 2 3 4 5	
fellow students	1 2 3 4 5	1 2 3 4 5	
campus doctor	1 2 3 4 5	1 2 3 4 5	
Faculty Special Needs Co-ordinator	1 2 3 4 5	1 2 3 4 5	
special needs tutor	1 2 3 4 5	1 2 3 4 5	
other (who)	1 2 3 4 5	1 2 3 4 5	

21. Do you have any other comments you'd like to make about the help you have (or have not) received at TAFE or university?

PART D What do you think about studying?

22. I get a lot of satisfaction from studying.

1	2	3	4	5
strongly agree	agree	undecided	disagree	strongly disagree

23. I like being a student.

1	2	3	4	5
strongly agree	agree	undecided	disagree	strongly disagree

24. Studying at university/TAFE is what I expected.

1	2	3	4	5
strongly agree	agree	undecided	disagree	strongly disagree

25. I worked as much as I could in first semester.

1	2	3	4	5
strongly agree	agree	undecided	disagree	strongly disagree

26. After a while, I lose sight of my goals.

1	2	3	4	5
strongly agree	agree	undecided	disagree	strongly disagree

27. I lack the drive to get my work done.

1	2	3	4	5
strongly agree	agree	undecided	disagree	strongly disagree

28. I find it hard to get going on anything important.

1	2	3	4	5
strongly agree	agree	undecided	disagree	strongly disagree

29. I am focussed on the direction I want my life to go in.

1	2	3	4	5
strongly agree	agree	undecided	disagree	strongly disagree

30. In my view, I have been really 'together' most of the time this year.

1	2	3	4	5
strongly agree	agree	undecided	disagree	strongly disagree

31. In my view, I have what it takes to be a successful student.

1	2	3	4	5
strongly agree	agree	undecided	disagree	strongly disagree

32. What were your last academic results? (Overall result)

Fail ☐ Pass ☐ Credit ☐ Honours ☐

33. I was happy with my last semester results:

1 2 3 4 5
strongly agree agree undecided disagree strongly disagree

PART E What can universities/TAFEs do to help?

Here are a number of suggestions people have made about useful supports for studying at University or TAFE. Please rate how useful they would be to you by circling the appropriate number.

34. I would like a quiet space where I can go if I feel stressed.

1 2 3 4 5
strongly agree agree undecided disagree strongly disagree

35. I would like to have someone I can talk to when I need it.

1 2 3 4 5
strongly agree agree undecided disagree strongly disagree

36. I would like more flexibility in course completion times.

1 2 3 4 5
strongly agree agree undecided disagree strongly disagree

37. I would like more flexibility in assessment tasks, (eg; extensions, alternative exam arrangements)

1 2 3 4 5
strongly agree agree undecided disagree strongly disagree

38. I would like study skills help.

1 2 3 4 5
strongly agree agree undecided disagree strongly disagree

39. I would like extra tutorial assistance for specific subjects.

1 2 3 4 5
strongly agree agree undecided disagree strongly disagree

40. I would like a peer mentor or 'study buddy'.

1 2 3 4 5
strongly agree agree undecided disagree strongly disagree

41. I would like more flexibility in my course timetable.

1 2 3 4 5
strongly agree agree undecided disagree strongly disagree

42. I would like more opportunity to give feedback to my university/TAFE as a consumer.

1 2 3 4 5
strongly agree agree undecided disagree strongly disagree

43. I would like to talk to one staff person who could, with my consent, liaise with other staff about my needs, as necessary.

1 2 3 4 5
strongly agree agree undecided disagree strongly disagree

44. I would like that person to be:

Disability Liaison Officer	☐	counsellor	☐
study skills advisor	☐	teacher/lecturer	☐
administrative officer	☐	course advisor	☐
on campus psychiatrist	☐	psychiatric nurse	☐
external case manager	☐	other: _____	

45. I think lecturers/teachers need more training on mental health issues

1 2 3 4 5
strongly agree agree undecided disagree strongly disagree

46. What suggestions would you make to improve study at university/TAFE?

Please indicate which state/territory you are studying in:

Victoria	☐	Qld	☐	SA	☐	NT	☐
NSW	☐	Tas	☐	ACT	☐	WA	☐

Thank you for taking the time to fill in this survey, we hope it will result in increased understanding and improved services for students studying at universities and TAFEs.

Patricia McLean and Jana Andrews

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Parkville, 3052
VICTORIA

We would appreciate it if the survey could be returned by November 15

If you have any questions or concerns, please contact:
Jana Andrews or Patricia McLean on 03 9344 8030/0029
or email: p.mclean@elp.unimelb.edu.au

Mental Health Issues in Post-Secondary Education Staff Survey

Thank you for taking the time to complete this survey. We are very interested to hear your views about how to help students with mental health problems who are studying at university or TAFE. Your answers are completely confidential and it will not be possible to identify individual responses. The results will be analysed and the information provided to universities, TAFE institutions and private training colleges to help them improve the services available to students. In addition to surveying teaching and support staff, we have also asked similar questions of students and prospective students.

Jana Andrews and Patricia McLean

Please return completed surveys to:

*PsychDis Project
Equity and Learning Programs Unit
University of Melbourne
Parkville, 3052
VICTORIA*

We would appreciate it if surveys could be returned by November 15

If you have any questions or concerns, please contact:
Jana Andrews or Patricia McLean on 03 9344 8030/0029
or email: p.mclean@elp.unimelb.edu.au

This survey is part of the *PsychDis* Project, an NCVER funded project investigating the support needs of students with mental health issues who are studying in post secondary education. A DEET co-operative projects grant for students with diverse needs has enabled the research to be extended to higher education students

MENTAL HEALTH ISSUES IN POST-SECONDARY EDUCATION SURVEY

A Please tell us a bit about yourself

1. How long have you been working in post-secondary education?

- < 1 year ☐ 1-3 years ☐ 4-5 years ☐
 5-10 years ☐ >10 years ☐

2. Are you a:

- | | | | |
|----------------------------|--------------------------|---------------------|--------------------------|
| Disability Liaison Officer | ☐ | counsellor | ☐ |
| study skills adviser | ☐ | teacher/lecturer | ☐ |
| administrative officer | ☐ | course adviser | ☐ |
| student adviser | ☐ | manager | ☐ |
| medical officer | ☐ | special needs tutor | ☐ |
| course co-ordinator | ☐ | other | _____ |

3. Do you work in a TAFE? ☐ a university? ☐ private training college ☐

PART B Please tell us a bit about your experience of students with mental health issues at university/TAFE

4. Have any of the students you worked with experienced any of the following conditions:
(You may indicate more than one)

- | | | | |
|---------------------------------|--------------------------|--------------------------------|--------------------------|
| Major depression | ☐ | Panic disorder | ☐ |
| Bipolar disorder | ☐ | Phobia | ☐ |
| | | Obsessive compulsive | ☐ |
| | | Acute stress reaction | ☐ |
| | | Post traumatic stress disorder | ☐ |
| | | Adjustment disorder | ☐ |
| Psychosis | ☐ | Learning disorder | ☐ |
| Schizophrenia | ☐ | Asperger's disorder | ☐ |
| Schizoaffective disorder | ☐ | ADD/ADHD | ☐ |
| | | Conduct disorder | ☐ |
| Anorexia Nervosa or Bulimia | ☐ | | |
| Borderline personality disorder | ☐ | | |
| Alcohol or drug dependence | ☐ | Other: | _____ |
| Diagnosis not known | ☐ | | |

5. In your opinion, has the number of students disclosing mental health problems studying at university or TAFE increased in the last few years?

Yes ☐ No ☐ Do you have data to support this? Yes ☐ No ☐

6. Which of the following aspects of studying at university/TAFE do you think are affected by a student's mental health condition. You may indicate more than one.

concentration in classes	☐	concentration when studying	☐
motivation	☐	problem solving	☐
reading skills	☐	writing skills	☐
keeping to deadlines	☐	adapting to college social life	☐
remembering	☐	organisational skills	☐
regular class attendance	☐	relating to people	☐
communicating	☐	ability to seek help	☐
sitting for exams	☐	feeling at home on campus	☐
attendance	☐	class participation	☐
confidence	☐	other? _____	

7. Has your institution experienced any of the following concerns with students with mental health problems?

Aggressive behaviour	☐	Failure to complete course within time limits	☐
Odd behaviour	☐	Such as: _____	
Other anti social behaviour	☐	Such as: _____	
Other? _____			

8. Would you advise a student to disclose a mental health problem?

Yes ☐ No ☐
Why? _____

9. Do you think you should be advised if a student has a mental health problem?

Yes ☐ No ☐
Why? _____

10. What would you like to see included in staff training programs on mental health issues?

Information about particular mental illnesses	☐
Information on disability legislation and students' rights	☐
Advice on handling difficult behaviour	☐
Advice on relating to students with mental health problems	☐
Advice on appropriate accommodations	☐
Advice on referral and liaison with psychiatric services	☐
Information on crisis management	☐
Other: _____	

11. Within the bounds of confidentiality, would you like the opportunity to:

discuss the case with a psychological/ psychiatric consultant ☐

discuss the case with other staff working with the student ☐

debrief ☐

PART C Bridging courses

12. Do you think students with mental health problems would attend a preparation for study bridging course if it were available?

Yes ☐

No ☐

13. Would you like to see bridging courses made available for students with mental health problems?

Yes ☐

No ☐

☐ (if no, go to Part D)

14. The ideal length of such a bridging course would be:

1- 5 days ☐

1- 4 weeks ☐

5 -10 weeks ☐

1 semester ☐

1 year ☐

other _____

15. Bridging course content would include (you may tick more than one):

motivation and goal planning ☐

confidence building ☐

orientation to university/TAFE ☐

stress management skills ☐

flexible delivery options ☐

time management ☐

stress management skills ☐

organisational skills ☐

reading skills ☐

notetaking skills ☐

oral presentation skills ☐

essay writing skills ☐

exam skills ☐

computing skills ☐

assertiveness training ☐

interpersonal skills ☐

16. Should bridging courses be run by educational institutions? ☐

Or by mental health organisations? ☐

PART D Useful supports for post-secondary study

Here are a number of suggestions people have made about useful supports for students with mental health problems studying in post-secondary institutions. Please indicate how useful you think they would be.

Please also indicate whether such supports are currently available at your institution.

Available Not available

17. A quiet space where students can go if they feel stressed.

1	2	3	4	5	☐	☐
strongly agree	agree	undecided	disagree	strongly disagree		

18. Staff to be available to talk to students (no appointment required).

1	2	3	4	5	☐	☐
strongly agree	agree	undecided	disagree	strongly disagree		

19. More flexibility in course completion times.

1	2	3	4	5	☐	☐
strongly agree	agree	undecided	disagree	strongly disagree		

20. Flexibility in assessment tasks.

1	2	3	4	5	☐	☐
strongly agree	agree	undecided	disagree	strongly disagree		

21. Study skills help.

1	2	3	4	5	☐	☐
strongly agree	agree	undecided	disagree	strongly disagree		

22. Additional tutorial assistance for specific subjects.

1	2	3	4	5	☐	☐
strongly agree	agree	undecided	disagree	strongly disagree		

23. Availability of a peer mentor or 'study buddy'.

1	2	3	4	5	☐	☐
strongly agree	agree	undecided	disagree	strongly disagree		

24. More flexibility in the student's course timetable.

1	2	3	4	5	☐	☐
strongly agree	agree	undecided	disagree	strongly disagree		

25. More opportunity for students to give consumer feedback to the university/TAFE.

1	2	3	4	5	☐	☐
strongly agree	agree	undecided	disagree	strongly disagree		

26. Availability of mediators in situations of conflict.

1	2	3	4	5	☐	☐
strongly agree	agree	undecided	disagree	strongly disagree		

27. A number of students have indicated they would like to be case managed by one staff member rather than have to talk to a number of different staff. Would you find this useful?

1	2	3	4	5
strongly agree	agree	undecided	disagree	strongly disagree

28. Who do you think would be best suited to this role?

Disability Liaison Officer	☐	counsellor	☐
study skills adviser	☐	teacher/lecturer	☐
administrative officer	☐	course adviser	☐
teacher/lecturer	☐	on campus medical officer	☐
on campus psychiatrist	☐	on campus psychiatric nurse	☐
external mental health adviser	☐	external case manager	☐
other _____			

29. What other supports do you provide for students with mental health problems?

30. What other suggestions do you have to improve the chances of successful outcomes for students with mental health problems?

All responses are completely confidential.

Thank you for taking the time to fill in this survey, we hope it will result in increased understanding and improved services for students studying in post-secondary education.

Patricia McLean and Jana Andrews

Please return the completed survey to:

PsychDis Project
Equity and Learning Programs Unit
University of Melbourne
Parkville, 3052
VICTORIA

We would appreciate it if the survey could be returned by November 15

If you have any questions or concerns, or would like further information, please contact:
Jana Andrews or Patricia McLean on 03 9344 8030/0029
or email: p.mclean@elp.unimelb.edu.au

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